



RENEWAL LICENSE APPLICATION FOR A HEALTH CARE INSTITUTION

ARIZONA DEPARTMENT OF HEALTH SERVICES

PUBLIC HEALTH LICENSING SERVICES – BUREAU OF LONG TERM CARE FACILITIES LICENSING

In accordance with A.R.S. §41-1030

B. An agency shall not base a licensing decision in whole or in part on a licensing requirement or condition that is not specifically authorized by statute, rule or state tribal gaming compact. A general grant of authority in statute does not constitute a basis for imposing a licensing requirement or condition unless a rule is made pursuant to that general grant of authority that specifically authorizes the requirement or condition.

D. This section may be enforced in a private civil action and relief may be awarded against the state. The court may award reasonable attorney fees, damages and all fees associated with the license application to a party that prevails in an action against the state for a violation of this section.

E. A state employee may not intentionally or knowingly violate this section. A violation of this section is cause for disciplinary action or dismissal pursuant to the Agency's adopted personnel policy.

F. This section does not abrogate the immunity provided by section 12 820.01 or 12 820.02.

I. HEALTH CARE INSTITUTION INFORMATION

| | | |
|--|---------------|-------------------|
| Name of Health Care Institution: _____ | | License No. _____ |
| Mailing Address: _____ | | |
| City: _____ | State: _____ | Zip Code: _____ |
| Phone No. _____ | Fax No. _____ | E-mail: _____ |

| |
|--|
| Class: Nursing Care Institution |
| What is the health care institution's scope of practice: |
| Health care institution's days and hours of operation: Sun _____ Mon _____ Tues _____ Wed _____ Thurs _____ Fri _____ Sat _____ |
| Is health care institution accredited? YES NO Name of accrediting organization (must be from a nationally recognized organization): SUBMIT, if applicable, a copy of the full accreditation report and cover letter. |
| Is health care institution requesting certification under Title XIX of the Social Security Act? YES NO |



RENEWAL LICENSE APPLICATION FOR A HEALTH CARE INSTITUTION

ARIZONA DEPARTMENT OF HEALTH SERVICES

PUBLIC HEALTH LICENSING SERVICES – BUREAU OF LONG TERM CARE FACILITIES LICENSING

II. OWNER INFORMATION

Owner's Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone No. _____ Fax No. _____

The owner is a (select one):

| | | |
|-------------------------------|---------------------------|---------------------|
| Sole proprietorship | Corporation | Partnership |
| Limited liability partnership | Limited liability company | Governmental agency |

If the owner is a partnership or a limited liability 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 two 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 name of an individual in charge of the health care institution designated in writing by the individual in charge of the governmental agency:

Name: _____ Title: _____

Name: _____ Title: _____

Name: _____ Title: _____

Has the owner or any 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 previous license application was submitted?

YES NO

If yes, indicate:

The reason for denial, revocation, or suspension:

The date of the denial, revocation, or suspension: _____

The name and address of the licensing agency that denied, revoked, or suspended the license :



RENEWAL LICENSE APPLICATION FOR A HEALTH CARE INSTITUTION

ARIZONA DEPARTMENT OF HEALTH SERVICES

PUBLIC HEALTH LICENSING SERVICES – BUREAU OF LONG TERM CARE FACILITIES LICENSING

Has the owner or any 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 previous license application was submitted?

YES NO

If yes, indicate:

The reason for denial, revocation, or suspension:

The date of the denial, revocation, or suspension: _____

The name and address of the licensing agency that denied, revoked, or suspended the license or certification:

Does the applicant agree to allow the Department to submit supplemental requests for information under A.A.C. R9-10-108(C)(2) ? YES NO

SUBMIT applicable fees required by R9-10-106. All fees are non-refundable except as provided in A.R.S. § 41-1077.

III. STATUTORY AGENT OR INDIVIDUAL WHO ACCEPTS SERVICE OF PROCESS AND SUBPOENAS

Name: _____ Title: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone No. _____

IV. GOVERNING AUTHORITY

Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____



RENEWAL LICENSE APPLICATION FOR A HEALTH CARE INSTITUTION

ARIZONA DEPARTMENT OF HEALTH SERVICES

PUBLIC HEALTH LICENSING SERVICES – BUREAU OF LONG TERM CARE FACILITIES LICENSING

V. CHIEF ADMINISTRATIVE OFFICER

Name: _____ Title: _____

Highest Educational Degree: _____

Work experience related to the health care institution class or subclass related to licensing requested:

VI. SIGNATURES

1. If the applicant is an individual, the owner of the health care institution.
2. If the applicant is a partnership or corporation, two of the partnership's or corporation's officers.
3. If the applicant is a governmental agency, the head of the governmental agency.

| | |
|-----------|-------|
| _____ | _____ |
| Signature | Title |
| _____ | _____ |
| Signature | Title |

VII. ADDITIONAL DOCUMENTATION

If the health care institution is located in a leased facility, submit a copy of the lease showing the rights and responsibilities of the parties and exclusive rights of possession of the leased facility.

Does the licensee have an accreditation report from a nationally recognized accrediting organization? YES NO

If yes, SUBMIT a copy of the health care institution's current accreditation report from a nationally recognized accrediting organization