



APPROVAL OF ARCHITECTURAL PLANS AND SPECIFICATIONS OF A HEALTH CARE INSTITUTION

ARIZONA DEPARTMENT OF HEALTH SERVICES
PUBLIC HEALTH LICENSING SERVICES

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. FOR CONSTRUCTION OF A NEW HEALTH CARE INSTITUTION (See page 4 for Modifications)

Name of Health Care Institution: _____

Street Address: _____

City: _____ Arizona Zip Code: _____

Phone No. _____

Name of Health Care Institution's Governing Authority or Licensee:

Street Address: _____

City: _____ Arizona Zip Code: _____

Email: _____

SELECT ONE: (check only one box)

HOSPITAL - Select one class or subclass (Listed in A.A.C. R9-10-102):

- General hospital
- Rural general hospital
- Special hospital (Psychiatric, Rehabilitation, Children's, Other specialty)

NURSING CARE INSTITUTION

OUTPATIENT SURGICAL CENTER

OUTPATIENT TREATMENT CENTER:

- OTC - Dialysis
- OTC in a Hospital
- OTC in a Nursing Care Institution
- OTC in an Assisted Living Center
- OTC - Freestanding Emergency Department

HOSPICE INPATIENT FACILITY

ASSISTED LIVING CENTER

ADULT DAY HEALTH CARE FACILITY

RECOVERY CARE CENTER



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HOSPITAL

Number of inpatient beds for each organized service or multi-organized service unit, not including well-baby bassinets:

Select organized units and indicate number of beds

	Requested Licensed Capacity
NICU (Neonatal)	_____
ICU-CCU (ICU – Cardiac Care Unit/Critical Care Unit)	_____
Continuing Care Nursery	_____
Pediatrics	_____
Postpartum	_____
LDRP (Labor, Delivery, Recovery and Postpartum)	_____
Medical/Surgical/Telemetry	_____
Psychiatric	_____
Rehabilitation	_____

Select type of Multi-Organized Service Units (MOSU) and indicate number of beds:

An **Adult** unit that provides both intensive care services and medical and nursing services other than intensive care services _____

A **Pediatric** unit that provides both intensive care services and medical and nursing services other than intensive care services _____

A unit that provides both perinatal services and intensive care services for **Obstetrical** patients _____

A unit that provides both intensive care services for neonates and a continuing care **Nursery** _____

TOTAL _____

If applicable, the bed occupancy for providing observation/stabilization services to:

Individuals under 18 years of age: _____

Individuals 18 years of age and older: _____

TOTAL _____



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The requested licensed capacity or occupancy for the health care institution:

OUTPATIENT SURGICAL CENTER

Select organized units and indicate number of beds

	Requested Licensed Capacity
Operating Rooms – Class A	_____
Operating Rooms – Class B	_____
Operating Rooms – Class C	_____
Recovery Beds – Class A	_____
Recovery Beds - Class B	_____
Post Anesthesia Recovery Beds – Class C	_____
Phase II Recovery Beds	_____
Endo Procedure Rooms	_____
Endo Procedure Recovery	_____
Procedure Rooms	_____

**Requested
Licensed
Capacity**

NURSING CARE INSTITUTION

INPATIENT HOSPICE FACILITY

ASSISTED LIVING FACILITY

Directed Care

Personal Care

OTC (OUTPATIENT TREATMENT CENTER)

Dialysis Center Stations/Chairs
in a Nursing Care Institution

N/A

in an Assisted Living Center

N/A

Emergency Room Services (Freestanding Emergency Care
Facility per 2010 FGI Guidelines 2.2-3.2)

ADHC (ADULT DAY HEALTH CARE)

Number of Participants

RECOVERY CARE CENTER



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FOR SUBSTANTIAL MODIFICATION [See R9-10-101 (172)] OF A LICENSED HEALTH CARE INSTITUTION

Name of Health Care Institution: _____

Existing License No. _____

Street Address: _____

City: _____ Arizona Zip Code: _____

Phone No. _____

Name of Health Care Institution's Governing Authority or Licensee:

Street Address: _____

City: _____ Arizona Zip Code: _____

Email: _____

Phone No. _____

SELECT ONE: (check only one box)

HOSPITAL - Select one class or subclass (Listed in A.A.C. R9-10-102):

- General hospital
- Rural general hospital
- Special hospital (Psychiatric, Rehabilitation, Children's, Other specialty)

NURSING CARE INSTITUTION

OUTPATIENT SURGICAL CENTER

OUTPATIENT TREATMENT CENTER

- OTC - DMN - Dialysis
- OTC in a Hospital
- OTC in a Nursing Care Institution
- OTC in an Assisted Living Center
- OTC - Freestanding Emergency Department

HOSPICE INPATIENT FACILITY

ASSISTED LIVING CENTER

ADULT DAY HEALTH CARE FACILITY

RECOVERY CARE CENTER



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HOSPITAL

Number of inpatient beds for each organized service or multi-organized service unit, not including well-baby bassinets:

Select organized units and indicate number of beds

	Existing Licensed Capacity	Add (+) # of Beds	Delete (-) # of Beds	Requested Licensed Capacity
NICU (Neonatal)	_____	_____	_____	_____
ICU -CCU (ICU – Cardiac Care Unit/Critical Care Unit)	_____	_____	_____	_____
Continuing Care Nursery	_____	_____	_____	_____
Pediatrics	_____	_____	_____	_____
Postpartum	_____	_____	_____	_____
LDRP (Labor, Delivery, Recovery and Postpartum)	_____	_____	_____	_____
Medical/Surgical/Telemetry	_____	_____	_____	_____
Psychiatric	_____	_____	_____	_____
Rehabilitation	_____	_____	_____	_____

Select type of Multi-Organized Service Units (MOSU) and indicate number of beds:

An **Adult** unit that provides both intensive care services and medical and nursing services other than intensive care services

A **Pediatric** unit that provides both intensive care services and medical and nursing services other than intensive care services

A unit that provides both perinatal services and intensive care services for **Obstetrical** patients

A unit that provides both intensive care services for neonates and a continuing care **Nursery**

TOTAL

If applicable, the bed occupancy for providing observation/stabilization services to:

Individuals under 18 years of age:

Individuals 18 years of age and older:

TOTAL

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The requested licensed capacity or occupancy for the health care institution:

OUTPATIENT SURGICAL CENTER

Select organized units and indicate number of beds

	Existing Licensed Capacity	Add (+)	Delete (-)	Requested Licensed Capacity
Operating Rooms – Class A	_____	_____	_____	_____
Operating Rooms – Class B	_____	_____	_____	_____
Operating Rooms – Class C	_____	_____	_____	_____
Recovery Beds – Class A	_____	_____	_____	_____
Recovery Beds - Class B	_____	_____	_____	_____
Post Anesthesia Recovery Beds – Class C	_____	_____	_____	_____
Phase II Recovery Beds	_____	_____	_____	_____
Endo Procedure Rooms	_____	_____	_____	_____
Endo Procedure Recovery	_____	_____	_____	_____
Procedure Rooms	_____	_____	_____	_____
	Existing Licensed Capacity	Add (+)	Delete (-)	Requested Licensed Capacity
NURSING CARE INSTITUTION	_____	_____	_____	_____
INPATIENT HOSPICE FACILITY	_____	_____	_____	_____
ASSISTED LIVING FACILITY				
Directed Care	_____	_____	_____	_____
Personal Care	_____	_____	_____	_____
OTC (OUTPATIENT TREATMENT CENTER)				
Dialysis Center Stations/Chairs in a Nursing Care Institution	N/A	_____	_____	_____
in an Assisted Living Center	N/A	_____	_____	_____
Emergency Room Services (Freestanding Emergency Care Facility per 2010 FGI Guidelines 2.2-3.2)	_____	_____	_____	_____
ADHC (ADULT DAY HEALTH CARE)				
Number of Participants	_____	_____	_____	_____
RECOVERY CARE CENTER	_____	_____	_____	_____

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II. CONTACT PERSON

Facility Contact Person Name: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Phone No. _____ Email address: _____

III. ARCHITECTURAL PLANS AND SPECIFICATIONS INFORMATION

Does the application include architectural plans and specifications? YES NO

If yes, submit:

1a. Project Architect's Name: _____

Project Firm's Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone No. _____ Email: _____

Alternate Phone No: _____

1b. A statement signed and sealed by the project architect that **the project architect has complied with A.A.C. R4-30-301 and that the architectural plans and specifications are in substantial compliance with applicable licensure requirements in A.R.S. Title 36, Article 4 and 9 A.A.C. 10.**

2. A statement signed by the governing authority or the licensee that **the architectural plans and specification comply with applicable licensure requirements in A.R.S. Title 36, Article 4 and 9 A.A.C. 10.**



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IV. PROJECT INFORMATION

Provide a narrative description of the project:

Estimated project cost, including: Site acquisition: \$ General construction: \$ Architect and Consultant fees: \$ Fixed equipment: \$ Movable equipment: \$ Total: \$

Does the applicant agree to allow the Department to submit supplemental requests for information under A.A.C. R9-10-108(C)(2)? [] YES

SUBMIT applicable Architectural Review fees required by R9-10-106. All fees are non-refundable except as provided in A.R.S. § 41-1077. Based on Estimated Total Project Costs above: \$ 0 to \$ 100,000 Fee: \$ 50.00 \$ 100,000 to \$ 499,999 \$100.00 \$ 500,000 and over \$150.00 Payment should be cashiers' check, money order or business check made payable to Arizona Department of Health Services. Cash and personal checks are not accepted.

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V. SUPPLEMENTAL DOCUMENTATION

1. If the health care institution is located on land under the jurisdiction of a local governmental agency:
 - a. A building permit:
 - i. For the construction or modification issued by the local governmental agency, or
 - ii. If not required, a zoning clearance issued by the local governmental agency that includes health care institution's:
 - Name, street address, city, state, and zip code;
 - Class or subclass; and
 - Each type of medical services, nursing services, or health-related services to be provided; and
 - A statement signed by a representative of the local governmental agency stating that the address listed is zoned for the health care institution's class or subclass.
2. A document that demonstrates that the project described on the application complies with the applicable codes and standards incorporated by reference in A.A.C. R9-1-412 and includes:
 - a. A table of contents:
 - i. The architectural plans and specifications submitted,
 - ii. The physical plant codes and standards incorporated by reference in A.A.C. R9-1-412 that apply to the project or are required by a local governmental agency,
 - iii. An index of the abbreviations and symbols used in the architectural plans and specifications, and
 - iv. The facility's specific International Building Code construction type and International Building Code occupancy type; and
 - b. If the facility is larger than 3,000 square feet and is or will be occupied by more than 20 individuals, the seal of an architect on the architectural plans and drawings according to the requirements in A.R.S. Title 32, Chapter 1;
 - c. A site plan, drawn to scale, of the entire premises showing streets, property lines, facilities, parking areas, outdoor areas, fences, swimming pools, fire access roads, fire hydrants, and access to water mains;
 - d. For each facility, on architectural plans and specifications:
 - i. A floor plan, drawn to scale, for each level of the facility, showing the layout and dimensions of each room, the name and function of each room, means of egress, and natural and artificial lighting sources;
 - ii. A diagram of a section of the facility, drawn to scale, showing the vertical cross-section view from foundation to roof and specifying construction materials;
 - iii. Building elevations, drawn to scale, showing the outside appearance of each facility;
 - iv. The materials used for ceilings, walls, and floors;
 - v. The location, size, and fire rating of each door and each window and the materials and hardware used, including safety features such as fire exit door hardware and fireproofing materials;
 - vi. A ceiling plan, drawn to scale, showing the layout of each light fixture, each fire protection device, and each element of the mechanical ventilation system;
 - vii. An electrical floor plan, drawn to scale, showing the wiring diagram and the layout of each lighting fixture, each outlet, each switch, each electrical panel, and electrical equipment;

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- viii. A mechanical floor plan, drawn to scale, showing the layout of heating, ventilation, and air conditioning systems;
 - ix. A plumbing floor plan, drawn to scale, showing the layout and materials used for water and sewer systems including the water supply and plumbing fixtures;
 - x. A floor plan, drawn to scale, showing the communication system within the health care institution including the nurse call system, if applicable;
 - xi. A floor plan, drawn to scale, showing the automatic fire extinguishing, fire detection, and fire alarm systems; and
 - xii. Technical specifications describing installation and materials used in the health care institution; and
3. A copy of the:
- i. Certificate of Occupancy issued by the governmental agency,
 - ii. Documentation that the facility was approved for occupancy, or
 - iii. Documentation that a Certificate of Occupancy for the facility is not available.
- a. A certification and a statement of substantial compliance with applicable licensure requirements in A.R.S. Title 36, Article 4 and 9 A.A.C. 10 signed by the project architect, the contractor, and the owner;
 - b. If applicable, a written description of any work necessary to complete the construction or modification submitted by the project architect;
 - c. If the construction or modification affects the health care institution's fire protection system, provide a contractor's certification and a description of the construction or modification for the:
 - i. Fire alarm system, and
 - ii. Automatic fire extinguishing system;
 - d. If the construction or modification affects the health care institution's heating, ventilation, or air conditioning, a copy of the heating, ventilation, air conditioning, and air balance tests and a contractor certification of the heating, ventilation, or air conditioning systems;
 - e. If draperies, cubicle curtains, or floor coverings are installed or replaced, a copy of the manufacturer's certification of flame spread for the draperies, cubicle curtains, or floor coverings;
 - f. For a health care institution using inhalation anesthetics or nonflammable medical gas, a copy of the Compliance Certification for Inhalation Anesthetics or Nonflammable Medical Gas System required in the National Fire Codes incorporated by reference in A.A.C. R9-1-412;
 - g. If a generator is installed, a copy of the installation acceptance required in the National Fire Codes incorporated by reference in A.A.C. R9-1-412;
 - h. For a health care institution providing radiology, a written report from a certified health physicist of the location, type, and amount of radiation protection; and

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- i. If a factory-built building is used by a health care institution:
 - a) A copy of the installation permit, and
 - b) A copy of a certificate of occupancy for the factory-built building from the Office of Manufactured Housing, or
 - c) A written report from an individual registered as an architect or a professional structural engineer under 4 A.A.C. 30, Article 2, stating that the factory-built building complies with applicable design standards;
4. A statement signed by the project architect that final architectural drawings and specifications have been submitted to the person applying for a health care institution license or the licensee of the health care institution.