INITIAL 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: ______________________________ Tax ID No.: ______________

Street Address: ____

City: ______________________ State: ______________ Zip Code: ______________

Mailing Address: ____

City: ______________________ State: ______________ Zip Code: ______________

Phone No. ____________________ Fax No. ______________ E-mail: ____________________

Class: ☐ Nursing Care Institution

☐ Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)

☐ Nursing Supported Group Homes (NSGH)

If a facility that is not required to comply with A.A.C. R9-1-412, indicate licensed capacity: ________________

Is the health care institution located within ¼ mile of agricultural land? ☐YES ☐NO

If yes, the name and address of each owner or lessee of agricultural land regulated under A.R.S. § 3-365.

Name of owner or lessee of agricultural land: ______________________________________

Street Address: ____

City:__________________ State:__________________ Zip Code: ______________

Name of owner or lessee of agricultural land: ______________________________________

Street Address: ____

City:__________________ State:__________________ Zip Code: ______________

SUBMIT, for each owner or lessee identified, a copy of the written agreement between the applicant and the owner or lessee of the agricultural land as prescribed in A.R.S. § 36-421(D).

Is the health care institution located in a leased facility? ☐ YES ☐ NO

If yes, provide a copy of the lease showing the rights and responsibilities of the parties and exclusive rights of possession of the leased facility.

Is the health care institution ready for a licensing inspection by the Department? ☐ YES ☐ NO

If no, indicate the date the health care institution will be ready for a licensing inspection: ___________________________

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

II. OWNER INFORMATION

The owner is a (select one):

☐ Sole proprietorship ☐ Corporation ☐ Partnership

☐ Limited liability partnership ☐ Limited liability company ☐ Governmental agency

Owner's Name: ____

Street Address: ____

City: ____ State: ________ Zip Code: __________________

Phone No. ___________________ Fax #: ____________________ Email: ____________________________________

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: ______________________________

SUBMIT, if applicable, a copy of the owner's articles of incorporation, partnership or joint venture documents, or limited liability documents.

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? ☐ 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 :

____

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? ☐ 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:

____

What is the health care institution's proposed scope of services?

____

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

III. SUPPLEMENTAL APPLICATION – NURSING CARE INSTITUTIONS **ONLY**

Does the nursing care institution have a secured area for a resident with Alzheimer's disease or other dementia?

☐ YES ☐ NO

Does the nursing care institution have an area for a resident on a ventilator?

☐ YES ☐ NO

Services provided (select all those that apply):

☐ Behavioral Health Services
☐ Clinical Laboratory Services
☐ Radiology Services and Diagnostic Imaging Services
☐ Rehabilitation Services
☐ Respiratory Care Services
☐ Dialysis Services

If applicable, name of the individual in charge of proposed nutrition and feeding assistant training program:

For each topic listed below (*on a separate page*) provide the information presented for each, the amount of time allotted to each, the skills an individual is expected to acquire for each, the testing method used to verify an individual has acquired the stated skills for each, and copies of the materials used during training in each:

a. Feeding techniques;
b. Assistance with feeding and hydration;
c. Communication and interpersonal skills;
d. Appropriate responses to resident behavior;
e. Safety and emergency procedures, including the Heimlich maneuver
f. Infection control;
g. Resident rights;
h. Recognizing a change in a resident that is inconsistent with the resident's normal behavior; or
i. Reporting a change in subsection (h) to a nurse at a nursing care institution.

IV. SUPPLEMENTAL APPLICATION – INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISBILITIES **ONLY**

Services provided (select all those that apply):

☐ Respiratory Care Services
☐ Clinical Laboratory Services
☐ Active Treatment to individuals under 18 years of age, including the licensed capacity requested
☐ Services to residents who have medical care plans

V. SUPPLEMENTAL APPLICATION – NURSING-SUPPORTED GROUP HOMES **ONLY**

Does the nursing-supported group home requesting authorization to admit residents with:

a. Ventilator

☐ YES ☐ NO

b. Have a tracheostomy tube

☐ YES ☐ NO

c. Receive total parenteral nutrition

☐ YES ☐ NO

Does the nursing-supported group home requesting authorization to provide the following:

a. Services to individuals under 18 years of age, including the licensed capacity requested

☐ YES ☐ NO

b. Restraint

☐ YES ☐ NO

c. Clinical laboratory services

☐ YES ☐ NO

d. Respiratory care services

☐ YES ☐ NO

SUBMIT a copy of the service provider award letter with the Division.

SUBMIT a copy of the licensee's service provider contract with the Division

VI. FEES

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

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

Name: ____________________ Title: ____________________

Street Address: ____

City: ____________________ State: ____________ Zip Code: ____________

Phone No.: ____________________

VIII. GOVERNING AUTHORITY

Name: ____________________ Title: ____________________

Street Address: ____

City: ____________________ State: ____________ Zip Code: ____________

IX. CHIEF ADMINISTRATIVE OFFICER

Name: ____________________ Title: ____________________

Highest Educational Degree: ____

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

X. SIGNATURES

A.R.S. §36-422(B) states an initial licensing application filed shall contain the written or electronic signature of:

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

XI. ADDITIONAL DOCUMENTATION

Is the health care institution required to comply with physical plant codes and standards incorporated by reference in A.A.C. R9-1-412?

☐ YES ☐ NO

If yes, provide documentation of the health care institution's architectural plans and specifications approval in R9-10-104. If no, provide one of the following:

- Documentation from the local jurisdiction of compliance with local building codes and zoning ordinances; or
- If documentation from the local jurisdiction is not available, documentation of the unavailability of the local jurisdiction compliance and documentation of a general contractor's inspection of the facility that states the facility is safe for occupancy as the applicable health care institution class or subclass;
- The licensed capacity requested by the applicant for the health care institution: ______________________
- If applicable, the licensed occupancy requested by applicant: ______________________
- A site plan showing each facility, the property lines of the health care institution, each street and walkway adjacent to the health care institution, parking for the health care institution, fencing and each gate on the health care institution premises, and if applicable, each swimming pool on the health care institution premises; and
- A floor plan showing, for each story of a facility, the room layout, room usage, each door and each window, plumbing fixtures, each exit, and the location of each fire protection device.