

ARIZONA DEPARTMENT OF HEALTH SERVICES

#### PUBLIC HEALTH LICENSING SERVICES - BUREAU OF MEDICAL 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 I	NFORMATIO	N	Date:
Name of Health Care Institution:			
Street Address:			
City:	State:	Zip Code:	
Mailing Address:			
City:	State:	Zip Code:	
Phone No		Email:	
Phone No Indicate type of application (select one):	Initial App	lication(never licensed)	Change of Classification
	Change of	Ownership (CHOW) cense #:	Provide License #: Change of Location (COL) Provide License #:
Select one class or subclass (Listed on A	.A.C. R9-10-1	02):	
General hospital	Rural genera	al hospital	Special hospital
Behavioral health inpatient facility	Home health	n agency	Unclassified health care institutions
Recovery care center	Hospice inp	atient facility	Hospice service agency
Outpatient surgical center	Outpatient tr	reatment center	Abortion clinic
Substance abuse transitional	Respite serv Colocation	ices (children):	Counseling facility
facility		lialysis stations:	Pain management clinic
Behavioral health specialized transitional facility	Number of c	observation/stabilization cha	irs
	ce service agei ES NO	ncy, or behavioral health fa	icility, is the health care institution located
If yes, provide the name and address of 6	each owner or l	essee of agricultural land re	egulated under A.R. S. § 3-365
Name of owner or lessee of agricultural	land:		
Street Address:			_
City:	State:	Zip C	ode:
Name of owner or lessee of agricultural			
Street Address:			
City:	State:		ode:
SUBMIT, for each owner or lessee iden of the agricultural land as prescribed in			ween the applicant and the owner or lessee



ARIZONA DEPARTMENT OF HEALTH SERVICES

PUBLIC HEALTH LICENSING SERVICES – BUREAU OF MEDICAL FACILITIES LICENSING

Is the health care institution lo If yes, provide a copy of the leas leased facility.		•		rties and exclus	ive rights of posses	sion of the
Is the health care institution rule. If no, indicate the date the health care institution rule.					NO	
Health care institution's days a	nd hours of oper	ation (i.e. 8-5, 8:0	0a-5:00p):			
Sun	M	T	W	T	F	Sat
Admv Hours:						
Respite Hours:						
Is health care institution accre	edited?   YE	S □NO				
Name of accrediting organiza	tion (must be fro	om a nationally re	cognized orga	anization):		
SUBMIT, if applicable, a copy	y of the full acc	reditation report a	and cover lette	er.		
Is health care institution reque	esting certification	on under Title XI	X of the Socia	al Security Ac	t? (Behavioral He	alth ONLY)
YES NO	•			•	`	ŕ
II. OWNER INFORMATION	V					
	11					
The owner is a (select one):						
Sole proprietorship Limited liability partnersl	hin	Corporation	ity oomnony		Partnership	
Limited hability partilers	шр	Limited liabil	ity company		Governmental	agency
Owner's Name (Name of corpo	oration, LLC, etc)	:				
Street Address:						
City:	State:			Zip C	ode:	
Phone No.	Email:				-	
If the owner is a partnership of	or a limited liab	ility partnership,	the name of e	ach partner;		<u>.</u>
If the owner is a limited liabil	lity company, th	ne name of the de	signated mana	ager or, if no	manager is design	ated, the names
of any two members of the li	mited liability c	ompany;				
If the owner is a corporation,	the name and ti	tle of each corpor	ate officer; or	<u>.</u>		
If the owner is a governmenta	al agency, the na	ame and title of th	e individual in	n charge of th	e governmental ag	gency or the
name of an individual in chargovernmental agency:				•		•
Name:		,	Γitle:			
Name:						
Name:						
			-			



ARIZONA DEPARTMENT OF HEALTH SERVICES
PUBLIC HEALTH LICENSING SERVICES – BUREAU OF MEDICAL FACILITIES LICENSING

If applicable, SUBMIT 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 (based on class or subclass selected on page 1)?
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
Emergency Contact Name:
Phone No
Email:



ARIZONA DEPARTMENT OF HEALTH SERVICES
PUBLIC HEALTH LICENSING SERVICES – BUREAU OF MEDICAL FACILITIES LICENSING

## III. SUPPLEMENTAL APPLICATION – HOSPITALS ONLY

The licensed capacity approved according to R9-10-104 for the:
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
□ NICU (Neonatal)
□ PICU (Pediatric)
□ PICU-PEDS (Pediatric ICU - Pediatrics)
☐ ICU-CCU (ICU – Cardiac Care Unit/ Critical Care Unit)
□ ICU-MS (ICU - Universal Med/Surg. Beds)
☐ Continuing Care Nursery
□ Pediatrics
□ Postpartum
☐ LDRP (Labor, Delivery, Recovery and Postpartum)
☐ Medical/Surgical/Tele
□ Psychiatric
☐ Rehabilitation
Select type of multi-organized service units 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,
If applicable, the licensed occupancy for providing observation/stabilization services to:
Individuals under 18 years of age:
Individuals 18 years of age and older:
IDENTIFY all medical staff specialties and subspecialties, ATTACH LIST to initial license application.



ARIZONA DEPARTMENT OF HEALTH SERVICES
PUBLIC HEALTH LICENSING SERVICES – BUREAU OF MEDICAL FACILITIES LICENSING

In addition to the supplemental application requirements above and if a hospital is requesting a SINGLE GROUP LICENSE. authorized in A.R.S. § 36-422(F), the following information for each satellite facility providing medical services, nursing services, or health-related services under the single group license: Name of Satellite Facility: Street Address: City: State: Zip Code: Phone No. Name of Administrator: Phone No. Email: Hours of Operation: Name of Satellite Facility: Street Address: Phone No. Name of Administrator: Phone No. Email: Hours of Operation: In addition to the supplemental application requirements above and if a hospital is requesting a SINGLE GROUP LICENSE, authorized in A.R.S. § 36-422(G), the following information for each ACCREDITED satellite facility providing medical services, nursing services, or health-related services under the single group license: Name of ACCREDITED Satellite Facility: Street Address: State: Zip Code: City: Phone No. \_\_\_\_\_ Name of Administrator: Phone No. \_\_\_\_\_ Email: \_\_\_\_\_ Hours of Operation: SUBMIT a copy of the ACCREDITED satellite facility's current accreditation report.



# ARIZONA DEPARTMENT OF HEALTH SERVICES PUBLIC HEALTH LICENSING SERVICES – BUREAU OF MEDICAL FACILITIES LICENSING

Name of ACCREDITED Satellite Facility:		
Street Address:		
City:	State:	Zip Code:
Phone No:		
Name of Administrator:		_
Phone No Email:		
Hours of Operation:		
SUBMIT a copy of the ACCREDITED satellite facilit	ty's current accreditation report.	
Name of ACCREDITED Satellite Facility:		
Street Address:		
City:	State:	Zip Code:
Phone No:		
Name of Administrator:		
Phone No Email:		
Hours of Operation:		
SUBMIT a copy of the ACCREDITED satellite facilit IV. SUPPLEMENTAL APPLICATION – HOSPICES For a hospice service agency:	1	
Hours of operation for the hospice's administrativ	ve office:	
Geographic region served:		
For a hospice inpatient facility, requested licensed ca		



ARIZONA DEPARTMENT OF HEALTH SERVICES

PUBLIC HEALTH LICENSING SERVICES – BUREAU OF MEDICAL FACILITIES LICENSING

#### V. SUPPLEMENTAL APPLICATION - OUTPATIENT TREATMENT CENTERS ONLY

Days and hours of clinical operations:  If different from the days and hours of clinical operations, the day and hours of administrative operations:	or an outpatient treatmen	in center.	
If different from the days and hours of clinical operations, the day and hours of administrative operations:	Days and hours of cli	inical operations:	
	If different from the o	days and hours of clinical operations, the day and hours of administrative operations:	

## VI. SUPPLEMENTAL APPLICATION (cont'd) – OUTPATIENT TREATMENT CENTERS ONLY

VI. GOTTEENERVITEENT EINTEN (COME)				
Select all specific services that apply:	Colocation requiremements	Medication services		
Diagnostic imaging services	Clinical laboratory services	Dialysis services		
Emergency room services	Pain management services	Physical health services		
Rehabilitation services	Sleep disorder services	Counseling services		
Urgent care services provided in a free s	Abortion clinic			
Behavioral health services, and if applicable:				
Court-ordered evaluation	Pre-petition screening	Opioid treatment services		
Court-ordered treatment	Crisis services	Respite services (children)		
DUI treatment	DUI screening			
DUI education				
Misdemeanor domestic violence offender treatment				
Behavioral health observation/stabilization services				
Behavioral health observation/stabilization services to individuals under 18 years of age				
None of the above				

Page 7 Rev. 11/18



ARIZONA DEPARTMENT OF HEALTH SERVICES

PUBLIC HEALTH LICENSING SERVICES – BUREAU OF MEDICAL FACILITIES LICENSING

#### VII. SUPPLEMENTAL APPLICATION - AFFILIATED OUTPATIENT TREATMENT CENTERS ONLY

In addition to the supplemental application requirements in A.R.S. § 36-422 and 9 A.A.C. 10, Article 1, a governing authority of an Affiliated Outpatient Treatment Center, as defined in R9-10-1901, applying for an initial or renewal license for the Affiliated Outpatient Treatment Center shall submit the following information for each counseling facility for which the Affiliated Outpatient Treatment Center is providing administrative support:

Name of Counseling Facility:			
Street Address:			
City:	State:	Zip Code:	
Phone No.			
Name of Administrator			
Phone No	Email:		
Hours of Operation:			
Name of Counseling Facility:		<u></u>	
Street Address:			
City:	State:	Zip Code:	
Phone No.			
Name of Administrator:			
Phone No	Email:		
Hours of Operation:			
Name of Counseling Facility:			
Street Address:			
City:	State:	Zip Code:	
Phone No.			
Name of Administrator:			
Phone No	Email:		
Hours of Operation:			

Page 8 Rev. 11/18



ARIZONA DEPARTMENT OF HEALTH SERVICES
PUBLIC HEALTH LICENSING SERVICES – BUREAU OF MEDICAL FACILITIES LICENSING

## VIII. SUPPLEMENTAL APPLICATION - HOME HEALTH AGENCIES ONLY

For a home health agency BRANCH OFFICE	complete information below:	
Name of Proposed Branch Office:		
Street Address:		
City:	State:	Zip Code:
Geographic region served:		
Name of Proposed Branch Office:		
Street Address:		
City:	State:	Zip Code:
Geographic region served:		
Name of Proposed Branch Office:		
Street Address:		
City	State:	Zip Code:
Geographic region served:		
SUBMIT to the Department a copy of a valid	• 1	
Article 3.1 for the applicant, if the applicant		aual with a 10% or greater ownership of the
business organization, if the applicant is a bus	smess organization.	

Page 9 Rev. 11/18



DEPARTMENT OF HEALTH SERVICES

#### PUBLIC HEALTH LICENSING SERVICES – BUREAU OF MEDICAL FACILITIES LICENSING

#### IX. SUPPLEMENTAL APPLICATION - COLOCATION

R9-10-1031 Colocation Requirements: The following information for each proposed colocator that may share a common area and non-treatment personnel at the collaborating outpatient treatment center. For each proposed associated licensed provider:

Associated license provide	er's name:				
OR Date the associated license	Associated licensed provider's license number:  OR  Date the associated licensed provider submitted to the department an initial license application for an outpatient reatment center or a counseling facility license:				
Proposed Scope of Service	es:				
Name of associated license	ed provider's governing authority:				
Will the associated license YES NO	ed provider share medical records with the collaborating outpatient treatment center:				
specify information (in the -General consent or info -Consent to allow a colo -Consent to allow a colo -SUBMIT a copy of the wr	provider plans to share medical records with the collaborating Outpatient Treatment Center, written agreement) about which party will obtain a patient's:  rmed consent (if applicable) recator access to the patient's medical record recator access to the patient's advance directives  ritten agreement with the collaborating Outpatient Treatment Center and a floor plan that possed treatment area and the common areas of the collaborating outpatient treatment center.				
Associated license provide	er's name:				
OR Date the associated license	Associated licensed provider's license number:  OR  Date the associated licensed provider submitted to the department an initial license application for an outpatient treatment center or a counseling facility license:				
Proposed Scope of Service	es:				
Name of associated licens	sed provider's governing authority:				
	ed provider share medical records with the collaborating outpatient treatment center?				
IF the associated licensed provider plans to share medical records with the collaborating Outpatient Treatment Center, specify information ( <i>in the written agreement</i> ) about which party will obtain a patient's:  -General consent or informed consent (if applicable)  -Consent to allow a colocator access to the patient's medical record  -Consent to allow a colocator access to the patient's advance directives					

**SUBMIT** a copy of the written agreement with the collaborating Outpatient Treatment Center and a floor plan that shows

each colocator's proposed treatment area and the common areas of the collaborating outpatient treatment center.

Page 10 Rev. 11/18



ARIZONA DEPARTMENT OF HEALTH SERVICES

PUBLIC HEALTH LICENSING SERVICES – BUREAU OF MEDICAL FACILITIES LICENSING

## X. SUPPLEMENTAL APPLICATION - SUBSTANCE ABUSE TRANSITIONAL FACILITY ONLY

For a substance abuse transitional facility, the licensed capacity for:  Individuals under 18 years of age:
Individuals 18 years of age and older:
XI. SUPPLEMENTAL APPLICATION – BEHAVIORAL HEALTH INPATIENT FACILITY ONLY
For a behavioral health inpatient facility, select all specific services that apply:
Detoxification services
Court-ordered pre-petition screening Court-ordered evaluation Court-ordered treatment
Clinical laboratory services
Restraint/Seclusion
Behavioral health observation/stabilization services including the licensed occupancy requested for providing behavioral health observation/stabilization services to individuals:
Under 18 years of age
18 years of age and older
Inpatient services to individuals under 18 years of age, include the licensed capacity requested:

## XII. FEES

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

Page 11 Rev. 11/18



ARIZONA DEPARTMENT OF HEALTH SERVICES

PUBLIC HEALTH LICENSING SERVICES – BUREAU OF MEDICAL FACILITIES LICENSING

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

Nama		Title	
Name:		Title:	
Street Address:			
City:	State:	Zip Code:	
Phone No.			
XIV. GOVERNING AUTHORITY			
Name:			
Street Address:			
City:	State:	Zip Code:	
XV. CHIEF ADMINISTRATIVE OFFICER			
Name:			
Highest Educational Degree:			
Phone No Email:			
Work experience related to the health care institution of	class or subclass related to licen	sing requested:	
XVI. SIGNATURES			
A.R.S. §36-422(B) states an initial licensing application of the applicant is an individual, the owner of the health of the applicant is a partnership or corporation, two of the applicant is a governmental agency, the head of	n care institution.  The partnership's or corporation	n's officers.	
Signature	Title	Date	
Signature	Title	Date	

Page 12 Rev. 11/18



ARIZONA DEPARTMENT OF HEALTH SERVICES

PUBLIC HEALTH LICENSING SERVICES – BUREAU OF MEDICAL FACILITIES LICENSING

#### XVII ADDITIONAL DOCUMENTATION

a. If the health care institution or a part of the health care institution is required by R9-10-105 to comply with any of the physical plant codes and standards incorporated by reference in A.A.C. R9-1-412, (applicable facilities: hospital, inpatient hospice, outpatient surgical center) documentation of the health care institution's architectural plans and specifications approval in

Except for a home health agency or hospice service agency, provide one of the following:

b. If a health care institution or part of the health care institution is not required by R9-10-105 to comply with any of the physical plant codes and standards incorporated by reference in A.A.C. R9-1-412:

1	The licensed capacity requested by the applicant for the health care institution:	
2	If applicable, the licensed occupancy requested by applicant:	

3 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,

R9-10-104 (submission of Application for Architecture Approval required); or

- fencing and each gate on the health care institution premises, and if applicable, each swimming pool on the health care institution premises;
- 4 A **floor plan** showing, for each story of a facility, the room layout (if colocation, designate areas), room usage, each door and each window, plumbing fixtures, each exit, and the location of each fire protection device and
- 5 One of the following:
  - a. Documentation from the local jurisdiction of compliance with local building codes and zoning ordinances; or
  - b. 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

Page 13 Rev. 11/18