Unclassified Health Care Institution
License Application

Arizona Department of Health Services
Division of 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. (E) 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. (F) 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. (G) 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:		
Street Address (Physical Facility):		
City:	State:	Zip Code:
Mailing Address:		
City:	State:	Zip Code:
Phone Number:	Email Address:	
Emergency Contact Name:		
Emergency Contact Phone Number:	Emergency Contact Email Address:	

Indicate type of application (select one):

- ☐ Initial Application (never licensed)
- ☐ Change of Ownership (CHOW); Provide License #:
- ☐ Change of Location (COL); Provide License #:
- ☐ Change of Classification; Provide License #:

Select one class or subclass (Listed in A.A.C. R9-10-102 and A.A.C. R9-10 Article 17):

- ☐ Unclassified Health Care Institution

Is the health care institution located within ¼ mile of agricultural land?
Note: This is not applicable for behavioral health facilities.

- ☐ No
- ☐ Yes (If selected, please include the name and address of each owner or lessee of agricultural land regulated under A.R.S. § 3-365 below. Please also **SUBMIT**, for each owner or lessee identified, a copy of a written agreement between the applicant and the owner or lessee of the agricultural land as prescribed in A.R.S. § 36-421(D))

Name of Owner/Lessee:

Street Address:

City: State: Zip Code:

Name of Owner/Lessee:

Street Address:

City: State: Zip Code:

Is the health care institution located in a leased facility?

- ☐ No
- ☐ Yes (If selected, please **SUBMIT** a copy of the fully executed lease agreement showing the rights and responsibilities of the parties and exclusive rights of possession of the leased facility)

Please include the health care institution's days and hours of operation below:

Admin Hours: Sun:_____ Mon:_____ Tues:_____ Wed:_____ Thurs:____ Fri:_____ Sat:_____

Clinic Hours: Sun:_____ Mon:_____ Tues:_____ Wed:_____ Thurs:____ Fri:_____ Sat:_____

Is the health care institution accredited?

- ☐ No
- ☐ Yes (If yes, provide name of nationally recognized accrediting organization

  Accrediting Organization:

Is the health care institution requesting certification under Title XIX of the Social Security Act (Medicaid)?

- ☐ No
- ☐ Yes

II. Owner Entity Information

Note: The owner's name should be consistent with the owner entity. For example, if the owner is a sole proprietor, the owner's name would be an individual's name. If the owner is a Limited Liability Company ("LLC"), the owner's name should be the name of the LLC.

Owner's Name:

Tax ID Number:

Owner's Mailing Address:

City: State: Zip Code:

Owner's Phone Number: Owner's Email Address:

Please select the <u>one</u> (1) applicable ownership type below:

- ☐ Sole proprietorship
- ☐ Corporation (If selected, please list the name and title of <u>each</u> corporate officer below.)
- ☐ Partnership (If selected, please list the name of <u>each</u> partner below.)
- ☐ Limited Liability Partnership (If selected, please list the name of <u>each</u> partner below.)
- ☐ Limited Liability Company (If selected, please list the name of the designated manager, or if no manager is designated, the names of any two (2) members of the limited liability company.)
- ☐ Governmental Agency (If selected, please list the name and title of the individual in charge of the governmental agency or the name of the 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:

Name: Title:

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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?

Note: This would include any health care institution license in any state/country/jurisdiction.

- ☐ No
- ☐ Yes (If selected, please answer the questions below.)
  - Please indicate whether the license was denied, revoked, or suspended:
  - Please indicate the name and address of the licensing agency that denied, revoked, or suspended the license:
  - Please detail the reason for the denial, revocation, or suspension, including the name and license number of the health care institution license that was denied, revoked, or suspended:
  - Please provide the date of the denial, revocation or suspension:

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?

- ☐ No
- ☐ Yes (If selected, please answer the questions on the next page below.)
  - Please indicate whether the license/certificate was denied, revoked, or suspended:
  - Please indicate the name and address of the licensing/certification agency that denied, revoked, or suspended the license/certificate:
  - Please detail the reason for the denial, revocation, or suspension, including the name of the individual and their license/certificate number that was denied, revoked, or suspended:
  - Please provide the date of the denial, revocation or suspension:

Is the health care institution ready for a licensing inspection by the Department?

- ☐ No; Indicate the date the health care institution will be ready for a licensing inspection:
- ☐ Yes

Does the applicant agree to allow the Department to submit supplemental requests for information under A.A.C. R9-10-108?

- ☐ No
- ☐ Yes

III. Statutory Agent (or Individual Who Accepts Service of Process and Subpoenas) Information

Name:

Title:

Street Address:

City: State: Zip Code:

Phone Number:

IV. Governing Authority Information

Name:

Mailing Address:

City: State: Zip Code:

V. Chief Administrative Officer Information

Name:

Title:

Highest Educational Degree:

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

VI. Scope of Services

Please detail the health care institution's proposed scope of services:

Note: The scope of services should include a list of the services the governing authority of a health care institution has designated as being available to a resident/participant at the health care institution and should meet the requirements of all regulations governing the applicable health care institution class or subclass.

VII. Supplemental Application Documentation

Please also ensure that the following documentation is **SUBMITTED** with this application:

- If the health care institution is located in a leased facility, a copy of the fully executed lease agreement showing the rights and responsibilities of the parties and exclusive rights of possession of the leased facility
- If applicable, a copy of the owner's articles of incorporation, partnership or joint venture documents, or limited liability documents
- If applicable, an Arizona Statement of Citizenship and Alien Status Form, per A.R.S. § 1-501 and supporting documents required to be submitted along with this form

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- Documentation from the local jurisdiction of compliance with applicable 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

- 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

- A floor plan showing, for each story of a facility, the room layout, room usage, each door and each window, plumbing fixtures (i.e. toilets, hand-washing sinks, bathtubs, showers, etc…), each exit, and the location of each fire protection device (i.e. smoke detectors, fire extinguishers, sprinklers, fire alarms, etc…)
  Note: If the Physical Plant Standards in the Arizona Administrative Code include minimum square footage requirements for the facility (i.e. bedrooms, residential units, indoor activity space, etc…), please include the total square footage, excluding any areas that should not be included in the total calculation (i.e. closets, bathrooms, halls, storage areas, kitchens, etc…).

- The **$50.00** non-refundable applicable application fee required by A.A.C. R9-10-106

- The Application & License Fee Remittance Form

- Any additional supplemental application requirements in specific rules in A.A.C. Title 9, Chapter 10 for the health care institution class or subclass for which licensing is requested

VIII. Signatures

Note: Per A.R.S. § 36-422(B), an application shall contain the written or electronic signature (as defined in A.R.S. § 44-7002) of:

1. ***If the applicant is an individual, the owner of the health care institution.***
2. ***If the applicant is a partnership, limited liability company or corporation, two (2) of the officers or the corporation or managing members of the partnership or limited liability company or the sole member of the limited liability company if it has only one (1) member.***
3. ***If the applicant is a governmental unit, the head of the governmental unit.***

By signing below, I agree or attest to the following:

- I have read and understand the Arizona Revised Statutes and Arizona Administrative Code regulations that govern the health care institution class or subclass for which licensing in requested and I agree to comply with those regulations.
- I attest that the information provided in the application is true, accurate and complete.
- I understand that per A.R.S. § 36-405(B)(5) and A.A.C. R9-10-106(G), all application and licensing fees are nonrefundable except as provided in A.R.S. § 41-1077.
- I understand that per A.A.C. R9-10-112(A), the Department may deny, revoke, or suspend a license to operate a health care institution if an applicant, a licensee, or a controlling person of the health care institution;
    - Provides false or misleading information to the Department;
    - Has had in any state or jurisdiction any of the following:
        - An application or license to operate a health care institution denied, suspended, or revoked, unless the denial was based on failure to complete the licensing process or to pay a required licensing fee within a required time-frame; or
        - A health care professional license or certificate denied, revoked, or suspended;
    - Does not comply with the applicable requirements in A.R.S. Title 36, Chapter 4 and A.A.C. Title 9, Chapter 10; or
    - Has operated a health care institution, within the preceding ten (10) years, in violation of A.R.S. Title 36, Chapter 4 or A.A.C. Title 9, Chapter 10, that posed a direct risk to the life, health, or safety of a patient.

Print Name	Print Title	Signature	Date
Print Name	Print Title	Signature	Date