Initial Behavioral Health Facility License Application

Arizona Department of Health Services
Division of Public Health Licensing Services
Bureau of Behavioral Health 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:		

Select the health care institution class or subclass you are requesting a license for.

Note: <u>Only one</u> (1) class or subclass should be selected and selecting the incorrect class or subclass will result in your application being withdrawn. It is essential that you review the regulations that govern the class or subclass you select below to ensure you are applying for the correct license.

- ◯ Adult Behavioral Health Therapeutic Home (see A.A.C. R9-10-101(13) and A.A.C. Title 9, Chapter 10, Article 18)
- ◯ Adult Residential Care Institution (see A.A.C. R9-10-101(14) and A.A.C. Title 9, Chapter 10, Article 7)
  Note: This is a subclass of a behavioral health residential facility that <u>only</u> admits residents 18 years of age and older and provides "recidivism reduction services" (see A.R.S. § 36-401(A)(41)).
- ◯ Behavioral Health Residential Facility (see A.A.C. R9-10-101(36) and A.A.C. Title 9, Chapter 10, Article 7)
- ◯ Counseling Facility (see A.A.C. R9-10-101(60) and A.A.C. Title 9, Chapter 10, Article 19)

- ◯ Behavioral Health Respite Home (see A.A.C. R9-10-101(37) and A.A.C. Title 9, Chapter 10, Article 16)
- ◯ Secure Behavioral Health Residential Facility – Secured (see A.R.S. § 36-425.06 and A.A.C. Title 9, Chapter 10, Article 7)

Note: This is a subclass of a behavioral health residential facility that provides secure twenty-four-hour on-site supportive treatment and supervision by staff with behavioral health training for persons who have been determined to be seriously mentally ill, who are chronically resistant to treatment for a mental disorder and who are placed in the facility pursuant to a court order issued pursuant to section 36-550.09. A secure behavioral health residential facility may provide services only to persons placed in the facility pursuant to a court order issued pursuant to section 36-550.09 and may not provide services to any other persons on that facility's premises.

Please include the health care institution's days and hours of operation below.
Note: All Behavioral Health subclasses should operate 24 hours/7 days a week excluding Respite Homes and Counseling Facilities.

Sun:_____ Mon:_____ Tues:_____ Wed:_____ Thurs:_____ Fri:_____ Sat:_____

For Counseling Facilities only, please specify the Administrative and Clinical hours of operation below:

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

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

Is the health care institution located in a leased facility?

Note: The lease should be between the property owner as listed in the county assessor's website (Landlord) and the owner entity of the health care institution (Tenant). The lease must also state the residence and/or property can be used as the health care institution "class or subclass" for which licensing is being requested.

- ◉ 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)

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 one (1) applicable ownership type below:

- ◯ Sole proprietorship
- ◯ Corporation (If selected, please list the name and title of each corporate officer below.)
- ◯ Partnership (If selected, please list the name of each partner below.)
- ◯ Limited Liability Partnership (If selected, please list the name of each 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.)

Please list the name and title of each individual or officer (Required for LLCs, LLPs, Corporations, Partnerships, and Governmental Agencies):

Name: Title:

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?

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?

Note: Examples may include an assisted living facility manager's certificate or any license/certificate issued by a Board of Nursing, Medical Board, etc… in any state/country/jurisdiction.

- ◯ 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:

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

Name:

Title:

Street Address:

City: State: Zip Code:

Phone Number:

IV. Governing Authority Information (The Controlling Person/Entity)

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 behavioral health services or physical health 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. **Services** (Please only fill out the section that corresponds to the health care institution class or subclass in which you are requesting a license. This section is not applicable for behavioral health respite homes, or adult behavioral health therapeutic homes.)

Behavioral Health Residential Facilities (See A.A.C. R9-10-702)

Please select the services you are planning to provide:

- ◯ Behavioral health services to individuals under 18 years of age
- ◯ Behavioral health services to individuals 18 years of age and older

If applicable, please select the supplemental services you are requesting authorization to provide:

- ☐ Behavioral health services to individuals 18 years of age or older whose behavioral health issue limits the individuals' ability to function independently
- ☐ Personal care services

☐ Respite services (If selected, please answer the questions below.)

- What is the requested number of individuals the behavioral health residential facility plans to admit for respite services who:
  - Are included in the requested licensed capacities for:
    - Behavioral health services to individuals under 18 years of age:
    - Behavioral health services to individuals 18 years of age and older:
  - Are under 18 years of age and who do not stay overnight in the behavioral health residential facility:
  - Are 18 years of age and older and who do not stay overnight in the behavioral health residential facility:

Are you requesting authorization to provide an outdoor behavioral health care program?

○ No

○ Yes (If selected, please answer the questions below and **SUBMIT** a copy of the outdoor behavioral health care program's current accreditation report.)

- What is the requested licensed capacity for providing the outdoor behavioral health care program to individuals in the following age groups?
  - 12 to 17 years of age:
  - 18 to 24 years of age:

<u>Counseling Facilities</u> (See A.A.C. R9-10-1902)

Please select the services you are planning to provide:

☐ Counseling to individuals 18 years of age and older

☐ Counseling to individuals under 18 years of age

If applicable, please select the supplemental services you are requesting authorization to provide:

☐ DUI Screening

☐ DUI Education

☐ DUI Treatment

☐ Misdemeanor Domestic Violence Treatment

Secure Behavioral Health Residential Facilities (See A.A.C. R9-10-702)

Note: Court-ordered evaluation and court-ordered treatment must be provided in compliance with the requirements in A.R.S. Title 36, Chapter 5, Article 5)

Please select the services you are planning to provide:

- ◯ Behavioral health services to individuals 18 years of age and older

Please select the services you are requesting authorization to provide?

- ☐ Court-ordered evaluation
- ☐ Court-ordered treatment
- ☐ Behavioral health services to individuals 18 years of age or older whose behavioral health issue limits the individuals' ability to function independently
- ☐ Personal care services

Adult Residential Care Institutions (See A.A.C. R9-10-702)

Please select the services you are planning to provide:

- ◯ Behavioral health services to individuals 18 years of age and older

Please select the services you are requesting authorization to provide?

- ☐ Recidivism reduction services
- ☐ Behavioral health services to individuals 18 years of age or older whose behavioral health issue limits the individuals' ability to function independently
- ☐ Personal care services

VIII. Supplemental Application Information

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

- ◯ No (If selected, please 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

*For **Behavioral Health Respite Homes** only*, please provide the following information for the health care institution's collaborating health care institution (see A.A.C. R9-10-1602):

Name of Collaborating Health Care Institution:

Class or subclass of Collaborating Health Care Institution:

License # of Collaborating Health Care Institution:

Street Address:

City: State: Zip Code:

For the individual assigned by the Collaborating Health Care Institution to monitor the behavioral health respite home, please include the individual's name: _____

Phone Number: Email Address:

For ***Adult Behavioral Health Therapeutic Homes** only,* please provide the following information for the health care institution's collaborating health care institution and backup provider (see A.A.C. R9-10-1802):

Name of the Backup Provider:

Name of Collaborating Health Care Institution:

Class or Subclass of Collaborating Health Care Institution:

License # of Collaborating Health Care Institution:

Street Address:

City: State: Zip Code:

For the individual assigned by the Collaborating Health Care Institution to monitor the adult behavioral health therapeutic home, please include the individual's name: _____

Phone Number: Email Address:

IX. 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

- If no part of the health care institution is required by A.A.C. Title 9, Chapter 10 to comply with any of the physical plant codes and standards incorporated by reference in A.A.C. R9-10-104.01:
    - 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

    - The licensed capacity requested by the applicant for the health care institution: _____

    - If applicable, the respite capacity requested by the applicant for the health care institution: _____

    - 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…).

- For Behavioral Health Residential Facilities requesting licensure for eleven (11) or more beds and for Assisted Living Centers, a copy of the health care institution's food establishment license or permit under 9 A.A.C. 8, Article 1
- For Behavioral Health Residential Facilities (A.A.C. R9-10-720(C)(1)) and Counseling Facilities (A.A.C. R9-10-1910(D)(1)), a copy of the current fire inspection from the local fire department or the State Fire Marshal
- 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

X. 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 is 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 **(physical or authenticated)**	Date
Print Name	Print Title	Signature **(physical or authenticated)**	Date