# Initial Health Care Institution License Application

**Arizona Department of Health Services**
**Division of 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 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. C. An agency shall not base a decision regarding any filing or other matter submitted by a licensee on a requirement or condition that is not specifically authorized by a statute, rule, federal law or regulation or state tribal gaming compact. A general grant of authority in statute does not constitute a basis for imposing a requirement or condition for approval of a decision on any filing or other matter submitted by a licensee unless a rule is made pursuant to that general not grant of authority that specifically authorizes the requirement or condition. D. An agency shall not: 1. Make a rule under a specific grant of rulemaking authority that exceeds the subject matter areas listed in the specific statute authorizing the rule. 2. Make a rule under a general grant of rulemaking authority to supplement a more specific grant of rulemaking authority. 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: ________________________ Tax ID No.: ____________

Street Address: ________________________________________________

City: ____________________ State: ____________ Zip Code: ____________

Mailing Address: ________________________________________________

City: ____________________ State: ____________ Zip Code: ____________

Phone No. ________________ Fax No. ____________ E-mail: ________________

☐ Nursing Care Institution (See A.A.C. Title 9, Chapter 10, Article 4)

☐ Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (See A.A.C. Title 9, Chapter 10, Article 5)

☐ Nursing Supported Group Homes (NSGH) (see A.A.C. Title 9, Chapter 10, Article 22)

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

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

For each topic listed below, 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**

Admit residents who:

a. Are on a ventilator

☐ YES ☐ NO

b. Have a tracheostomy tube

☐ YES ☐ NO

c. Receive total parenteral nutrition

☐ YES ☐ NO

Services Provided (select all those that apply:

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

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.: ____________________

## VII. GOVERNING AUTHORITY

Name: ______________________ Title: ______________________

Street Address: ______________________________________________

City: ____________________ State: ______________ Zip Code: ______________

## VIII. CHIEF ADMINISTRATIVE OFFICER

Name: ______________________ Title: ______________________

Highest Educational Degree: ______________________________________

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

## IX. 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 |