State of Alaska

Department of Health

Free Standing Birth Center State Licensure Application

DUE DATE: 90 DAYS PRIOR TO THE EXPIRATION OF YOUR CURRENT LICENSE (AS 47.32.060)

Pursuant to the AS 47.32 Licensing Statute and the regulations of the Department of Health Health Facilities Licensing requirements (7 AAC 10 and 7 AAC 12).

This application can be used for initial licensure applications and biennial license renewals. Please check the appropriate box below to indicate the purpose of this application.

Type of License Applying for (select one)**:** ◯ Initial Provisional Licensing ◯ Biennial Renewal License

General Instructions:

1. Application should be complete, clear and legible. After this application is completed, it should be printed, signed in permanent ink and submitted to the State of Alaska, Health Facilities Licensing & Certification team. Contact info is located below.

2. If more space is needed, additional pages can be attached as necessary. This also applies to any information that does not fit within the given space and should indicate "see attached page #" or something similar.

3. This application must be executed and verified by the individual owner or by two officers in the case of a corporation, association or governmental unit or agency.

4. There are licensure fees associated with this application. Please see 7 AAC 12.615 for more information regarding the fees due for your facility. If there are any questions about these fees, please contact 907-334-2483.

5. A separate application is required for facility branches operated on separate premises if that facility operates under a separate license number. Separate applications are required for each individual facility that is licensed separately, even though ownership is the same.

1. FACILITY DEMOGRAPHIC

State Licensing Number: _____

Legal Name: _____

Doing Business as: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Primary Phone Number: _____ Secondary Phone Number: _____

Primary Fax Number: _____ Secondary Fax Number: _____

Generic Email (*info@abcfacility.com*): _____

Other Locations Under Same Licensure:

Other locations under same licensure include facilities that are located in services area as the parent facility and shares administration, supervisors, and/or services with the parent facility on a daily basis.

Please provide the name and location of any secondary locations under the same established licensure:

Name:_____ Location: _____

Name:_____ Location: _____

Name:_____ Location: _____

2. ADMINISTRATION

Please provide the information below for all positions as they apply to your facility type.

a. Administrator (*required*):

Name: _____ Title:_____

Direct Phone: _____ Fax: _____

Email: _____

b. Medical Director / Director of Clinical Services (*if applicable*):

Name: _____ Title:_____

Direct Phone: _____ Fax: _____

Email: _____

c. Supervising Nurse / Director of Nursing (*if applicable*):

Name: _____ Title:_____

Direct Phone: _____ Fax: _____

Email: _____

3. ACCREDITATION (if applicable)

Is the facility be fully approved by and accreditation organization? Yes*: ◯ No: ◯

If ***yes***, please provide the following information:

Accrediting Organization: _____

Date of last Accrediting Body Survey: _____Type of Survey: _____

Date Accreditation Expires: _____Frequency of Accreditation Cycle: _____

**Facilities with accreditation through a nationally recognized organization may be eligible to waive their biannual State licensing survey for the current/upcoming licensing period. To apply, and for more information, please see the State Licensing Survey Waiver Application attached at the end of this application.*

4. OWNERSHIP & CONTROL

Governmental: ◯ State ◯ Borough ◯ City/Community

Non for Profit: ◯ Church Operated or Affiliated ◯ Corporation

Proprietary: ◯ Individual ◯ Partnership ◯ Corporation

Other (please explain): _____

a. Individual or Partnership Owned (list all persons who own the facility)

Name: _____ Address: _____

Name: _____ Address: _____

Name: _____ Address: _____

Name: _____ Address: _____

b. Names under which person(s) in (a.) do business (other than the facility indicated on this application)

Name: _____ Business: _____

Name: _____ Business: _____

Name: _____ Business: _____

Name: _____ Business: _____

c. Corporate Ownership

Name of Corporation: _____

State where Parent Firm or Organization is Incorporated or Registered: _____

List title, name, and address of each corporate officer: _____

Title: _____ Name: _____ Address: _____

Title: _____ Name: _____ Address: _____

Title: _____ Name: _____ Address: _____

Title: _____ Name: _____ Address: _____

d. List names and addresses of each shareholder holding more than 5% of shares OR ownership

Name: _____ State of Residence: _____ Percent of Shares: _____

Name: _____ State of Residence: _____ Percent of Shares: _____

Name: _____ State of Residence: _____ Percent of Shares: _____

Name: _____ State of Residence: _____ Percent of Shares: _____

Name: _____ State of Residence: _____ Percent of Shares: _____

e. If the property or building this facility is operating in is on a lease or rental agreement, please specify ownership.

f. Trust or Endowment Operated

Trustee Name:_____

Address: _____

City: _____ State: _____ Zip Code: _____

g. Additional Facility Operations

If the legal entity designated as the operator/licensee operates any other facility of this type, list the name and address of each facility, and attach letters from each state (other than Alaska) verifying licensure and compliance are required.

Facility Name:_____

Address: _____

City: _____ State: _____ Zip Code: _____

h. Have any of the individuals listed on under this section been convicted of a felony or two or more misdemeanors involving moral turpitude in the last 5 years?

If *yes*, attach a list of names and explanations as Exhibit I**:** Yes: ◯ No: ◯

5. CRIMINAL BACKGROUND CHECKS

Does the facility have a system in place for performing criminal background checks in accordance with **AS 47.05** and **7 AAC 10.900 - 990** through the Alaska Background Check Program (BCP)? Yes: ◯ No: ◯

6. INSURANCE

Does this facility have current Malpractice Insurance? Yes: ◯ No: ◯

Company: _____

Address: _____

Expiration Date: _____

7. EXPANSION/REDUCTION

Does your facility plan to add new or delete present services and/or facilities during the next period for which this licensed will be issued? Yes: ◯ No: ◯

If yes, please describe:

8. SERVICE AREA

Please describe the proposed or actual service area. Include any environmental factors that might affect access to the birth center or transfer to the hospital.

9. PERSONNEL

Provide full time equivalents (FTEs) for the following staffing areas:

	Employed Staff	Contractual	Total FTEs
Certified Nurse Midwives	_____	_____	_____
Direct Entry Midwives	_____	_____	_____
Registered Nurses	_____	_____	_____
Licensed Practical Nurses	_____	_____	_____
Nurse Practitioners	_____	_____	_____
Clinical Support Staff	_____	_____	_____
Others	_____	_____	_____

Is there an experienced physician or certified nurse midwife immediately available to the birth center by radio, telephone, or other means of communication for consultation or transfer of care? Yes: ◯ * No: ◯

*If yes, name of practitioner: _____

Current Alaska Licensing Number: _____ On Staff: ☐ Contract: ☐ On-Call: ☐

List the names of all the midwives practicing at the birth center:

Name of Practitioner	Current Alaska License Number
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

10. SERVICES AND PROGRAMS

a. Hospital Obstetrics & Newborn Services:

Nearest Hospital: _____

Distance from birth center to nearest hospital in miles: _____

Time required for transfer to hospital in normal conditions: _____

Does the hospital provide Obstetrics & Newborn Services? Yes: ◯ No: ◯

b. Birth Center Services & Programs

Does the birth center provide home birth services? Yes: ◯ No: ◯

Does the birth center provide a family-centered maternity care program? Yes: ◯ No: ◯

If no, is a family-centered maternity care program available in the service area? Yes: ◯ No: ◯

Does the birth center provide clinics for disadvantaged families? Yes: ◯ No: ◯

If no, are clinics available in the service area for disadvantaged families? Yes: ◯ No: ◯

List available clinics in service area for this service: _____

Does the birth center provide laboratory services? Yes: ◯ No: ◯

If yes, list services provided: _____

If yes, provide CLIA certificate number: _____

Does the birth center provide supplementary social and welfare services? Yes: ◯ No: ◯

If yes, describe services: _____

Does the birth center provide childbirth education? Yes: ◯ No: ◯

If no, are clinics available in the service area for childbirth education? Yes: ◯ No: ◯

Does the birth center provide parental support program? Yes: ◯ No: ◯

If no, are clinics available in the service area for parental support program? Yes: ◯ No: ◯

c. Facility Community Needs & Population (as applicable)

Describe the birth center's impact on the community and the needs of childbearing families in the population served:

Any changes in the population served since the pervious application was submitted? Yes: ◯ No: ◯

If yes, please describe:

11. FACILITY STATISICAL DATA (last 12 months)

How many births has the facility had at the birth center? _____

How many births with complications that required a transfer of the newborn to a hospital? _____

How many births with complications that required a transfer of the client to a hospital? _____

12. FACILITY PHYSICAL PLANT

How many birthing rooms does the facility have? _____

Does the facility have or anticipate any new additions and/or remodeling planned? Yes: ◯ No: ◯

If yes, please describe:

State of Alaska
Department of Health
Free Standing Birth Center
State Licensure Application

This form must be completed to finalize the transaction.

Licensing renewal fee amounts can be reviewed under **7 AAC 12.615.** For more information or for assistance calculating the fees for your facility, please contact HFLC at 907-334-2483 or by email at dhcs.hflc@alaska.gov

We accept payments by **check** and **credit card**.

To make a credit card payment by phone: **Call 907-334-2400, opt. 3**. You will be asked to provide the full facility name, state licensing number, and exact payment amount.

State Licensing Number: _____

Facility Type: Select One _____ **Payment Type:** Select One _____

Facility Name: _____

Facility Contact: _____ **Phone:** _____

Payment Amount (includes licensing and bed / branch fees if applicable): $ _____

Date of Credit Card Payment (indicated the date you made a payment by phone): _____

Payment by Check: **Check #**: _____ **Check Date**: _____

Make Checks Payable to: State of Alaska – HFLC

HFLC Mailing/Physical Address:
State of Alaska
Health Facilities Licensing & Certification
4601 Business Park Blvd. Bldg. K
Anchorage, AK 99503

For State of Alaska Accounting Use ONLY

DEPT: 06 **FUND**: 1004 **UNIT**: 4011 **APPR**: 062330704 **REVENUE**: 5101

Activity: ◯ 4HF0 - License/Renewal Fee ◯ 4HF1 - Revisit ◯ 4HF2 - Modification ◯ 4HF3 - Fine

Payment Received on: _____ Check # / CC Auth#: _____

Payment Received & Coded by: _____

Notes/Comments: _____

13. ATTESTATION

The applicant, or the person authorized to submit the application on behalf of an applicant that is not an individual, declares and certifies that the contents of this application and the information provided with it are true, accurate, and complete.

In addition, the applicant, or the person authorized to submit the application on behalf of an applicant that is not an individual, declares and certifies that he or she has reviewed the regulatory requirements contained in **7 AAC 10.900 - 990** (Barrier Crimes, Criminal History Checks, and Centralized Registry), **7 AAC 10.9500 -9535** (General Variance), **7 AAC 10.9600 - 9620** (Inspections and Investigations), the applicable requirements for facility type and the applicable requirements of **7 AAC 12.600 -990** (General Provisions).

The undersigned give assurance that the facility is in compliance to the best of his/her knowledge, and he/she is prepared for an on-site inspection to validate compliance.

_____ _____

Administrator or Designee Name **Date**

_____

Signature of Administrator or Designee

Submit this application and all required attachments via mail, hand delivered, faxed or email:

Health Facilities Licensing & Certification
4601 Business Park Blvd., Bldg. K, Anchorage, AK 99503

Phone: (907) 334-2483 **Fax**: (907) 334-2682

Email: dhcs.hflc@alaska.gov

State of Alaska
Department of Health
Free Standing Birth Center
State Licensure Application

State Licensure Survey Waiver Application

Facilities with accreditation through a nationally recognized organization may be eligible to waive their biannual State licensing survey for the current/upcoming licensing period. To learn more about the survey waiver an eligibility, please referto **7 ACC 12.925** and **AS 47.32.030(a)(9) (A-C).** To apply, please provide the following information.

Facility Type: Select One _____ AK License Number: _____

Facility Name: _____

Satellite Locations: Yes*: ◯ No: ◯ (*if yes, inspection reports for those sites are also required)

Physical Address: _____

Mailing Address: _____

Primary Phone: _____ Primary Fax: _____

Email for facility distribution list: _____

Administrator: _____ Administrator's Phone: _____

Administrator's E-Mail: _____

Secondary Contact: _____ Title: _____

Secondary's Phone: _____ Secondary's E-Mail: _____

Name of Accrediting Organization (AO): _____

Date of last inspection: _____ Frequency of accreditation cycles: _____

Were any deficiencies identified during last inspection? Yes: ◯ * No: ◯

*If yes, have the deficiencies been corrected? Yes: ◯ No: ◯

For surveys conducted in the past 2-3 months, in which the facility has not received the report or have an approved plan of correction – when do you expect to receive these documents? _____

Name of Person Completing Form: _____ Date: _____

*****A copy of your <u>last inspection report</u> and <u>plan of correction MUST</u> <u>be submitted with the application or the waiver will be denied</u>*****

FOR DIVISION USE ONLY

Date Application Received: _____ All attachments included: Yes: ☐ No: ☐

Application Reviewed by: _____ Date Reviewed: _____

Application is: Approved: ☐ Denied*: ☐

Reason for Denial: _____

Signature: _____ Date: _____