

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).

Licei	using requirements (/ AAC 10 a	inu / AAC 12).		
	application can be used for initial below to indicate the purpose of the		iennial license renewals. Please check the app	propriate
Туре	e of License Applying for (select	one): Initial Provisiona	al Licensing	;
Gene	eral Instructions:			
1		ubmitted to the State of Alask	is application is completed, it should be print ka, Health Facilities Licensing & Certification	
2			s necessary. This also applies to any informa "see attached page #" or something similar.	ition
3	This application must be executor corporation, association or government.		ridual owner or by two officers in the case of	î a
4			ease see 7 AAC 12.615 for more information stions about these fees, please contact 907-3	
5		er. Separate applications are r	rated on separate premises if that facility ope required for each individual facility that is lie	
1. <u>I</u>	FACILITY DEMOGRAPHIC	2		
S	State Licensing Number:			
Ι	Legal Name:	· · · · · · · · · · · · · · · · · · ·		
	Physical Address:			
(City:	State:	Zip:	
N	Mailing Address:			
(City:	State:	Zip:	
	Primary Phone Number:		dary Phone Number:	
P	Primary Fax Number:	Seco	ndary Fax Number:	

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Generic Email (info@abcfacility.com): __



2.

3.

State of Alaska

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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.

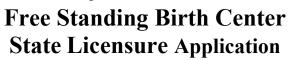
Name:	Location:
Name:	Location:
Name:	Location:
<u>ADMINISTRATION</u>	
Please provide the information below for all pos	sitions as they apply to your facility type.
. Administrator (required):	
Name:	Title:
Direct Phone:	Fax:
Email:	
o. Medical Director / Director of Clinical Se	rvices (if applicable):
Name:	Title:
Direct Phone:	Fax:
Email:	
. Supervising Nurse / Director of Nursing (,
Name:	Title:
Direct Phone:	Fax:
Email:	
ACCREDITATION (if applicable)	
s the facility be fully approved by and accredita	ation organization? Yes*: No:
f <i>yes</i> , please provide the following information	
Accrediting Organization:	
	Type of Survey:

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^{*}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.



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4. OWNERSHIP & CONTROL

Go	vernmental:		State	☐ Borough		City/Community
Non for Profit:			Church Op	erated or Affiliat	ted	Corporation
Proprietary:			Individual	☐ Partnership		Corporation
Otl	ner (please explai	n): _				
a.	Individual or P	artn	ership Owi	ned (list all pers	ons who ow	n the facility)
	Name:				Address:	
	Name:				Address:	
b.	Names under v	vhicł	n person(s)	in (a.) do busine	ess (other th	an the facility indicated on this application)
	Name:				Business:	
	Name:				Business:	
	Name:		· · · · · · · · · · · · · · · · · · ·	 	Business:	
	Name:				Business:	
			•			
c.	Corporate Own		-			
						Danishana I.
						Registered:
						ddragg
						ddress:
						ddress:
						ddress:
	Title:		Name:		A	ddress:
d.	List names and	l add	resses of ea	ch shareholder	holding mo	re than 5% of shares OR ownership
	Name:			S	tate of Resid	lence: Percent of Shares:
	Name:			S	tate of Resid	lence: Percent of Shares:
						lence: Percent of Shares:
						lence: Percent of Shares:
						lence: Percent of Shares:



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Additional Facility Operations If the legal entity designated as the operator/licensee operates any other facility of this type, list the nar address of each facility, and attach letters from each state (other than Alaska) verifying licensure and c are required. Facility Name: Address:	Address: City:	address of each facility, and attach letters from each state are required. Facility Name: Address: City: State: ave any of the individuals listed on under this section leads to the content of the	z (other than Alaska) verifying Zip Code: been convicted of a felony o	g licensure and cor
Trustee Name: Address: City: State: Zip Code: dditional Facility Operations If the legal entity designated as the operator/licensee operates any other facility of this type, list the nar address of each facility, and attach letters from each state (other than Alaska) verifying licensure and care required. Facility Name: Address:	Address: City:	address of each facility, and attach letters from each state are required. Facility Name: Address:	e (other than Alaska) verifying	g licensure and cor
Trustee Name: Address: City: State: Zip Code: dditional Facility Operations If the legal entity designated as the operator/licensee operates any other facility of this type, list the nar address of each facility, and attach letters from each state (other than Alaska) verifying licensure and care required. Facility Name: Address:	Address: City:	address of each facility, and attach letters from each state are required. Facility Name: Address:	e (other than Alaska) verifying	g licensure and cor
Trustee Name: Address: City: State: Zip Code: dditional Facility Operations If the legal entity designated as the operator/licensee operates any other facility of this type, list the nar address of each facility, and attach letters from each state (other than Alaska) verifying licensure and care required.	Address: City: State: Zip Code: Iditional Facility Operations If the legal entity designated as the operator/licensee operates any other facility of this type, list the named address of each facility, and attach letters from each state (other than Alaska) verifying licensure and coarse required.	address of each facility, and attach letters from each state are required.	e (other than Alaska) verifying	g licensure and cor
Trustee Name: Address: City: State: Zip Code: dditional Facility Operations	Trustee Name: Address: City: State: Zip Code: Iditional Facility Operations			
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Trustee Name:Address:	Γrustee Name:Address:	Uity: State:	Zıp Code:	
Trustee Name:	Γrustee Name:			
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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 facilit	ies during the next p	eriod 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 environm the birth center or transfer to the hospital.	ental factors that mig	ght affect	access to

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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 certific	ed nurse midwife imme	ediately available to the	e birth center by radio,
telephone, or other means of communication	on for consultation or tr	ransfer of care? Yes:	□ * No: □
*If yes, name of practitioner:			
Current Alaska Licensing Number:	(On Staff: Contra	ct: 🗆 On-Call: 🗆
List the names of all the midwives practicing	at the birth center:		
Name of Practitioner		Current Alaska Li	cense Number
			
			

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10. <u>SERVICES AND PROGRAMS</u>

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 famil	ies in the popu	ulation
	served:		



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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 ho	ospital?	
How many births with complications that required a transfer of the client to a hosp	ital?	
12. <u>FACILITY PHYSICAL PLANT</u>		
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:		

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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 <u>full facility name</u>, <u>state licensing number</u>, and <u>exact payment amount</u>.

<u> </u>
Payment Type:
Phone:
/ branch fees if applicable): \$
late you made a payment by phone):
Check Date:
LC Mailing/Physical Address: State of Alaska Facilities Licensing & Certification 1 Business Park Blvd. Bldg. K Anchorage, AK 99503
e of Alaska Accounting Use ONLY
UNIT: 4011 APPR: 062330704 REVENUE: 5101
\Box 4HF1 - Revisit \Box 4HF2 - Modification \Box 4HF3 - Fine
Check # / CC Auth#:

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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 1	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

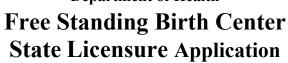
4601 Business Park Blvd., Bldg. K, Anchorage, AK 99503

Email: dhcs.hflc@alaska.gov

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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 refer to 7 ACC 12.925 and AS 47.32.030(a)(9) (A-C). To apply, please provide the following information.

Facility Type:	AK License Number:
Facility Name:	
Satellite Locations: Yes*: ☐ No: ☐ (*if ye	es, inspection reports for those sites are also required)
Physical 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: □
	he facility has not received the report or have an approved plan of nts?
Name of Person Completing Form:	Date:
	on report and plan of correction MUST ation or the waiver will be denied***
FOR D	IVISION USE ONLY
Date Application Received:	All attachments included: Yes: ☐ No: ☐
Application Reviewed by:	Date Reviewed:
Application is: Approved: □ Denied*: □	
Reason for Denial:	
Signature:	Date:

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