State of Alaska

Department of Health

Long Term Care Facility 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. BED CAPACITY

Definitions:

Bed complement: Give the present number of beds actually set up for active long-term care.

Bed capacity: Based only on space designed as patient rooms, whether or not beds are installed or active; compute the "normal" bed count requested in the application to be licensed.

	NUMBER OF BEDS
Total Bed Complement	______________
Bed Capacity (number of beds applying for)	______________
Number of resident care days rendered in the last calendar or fiscal year:	______________
Number of residents discharged and died during the same time period.	______________
Time period used for above calculations (Month/Year to Month/Year):	______________

Any patient beds located in rooms below ground level? Yes: ☐ No: ☐

If yes, how many? ______________

8. PERSONNEL

Please indicate the anticipated total number of full-time employees (FTE) employed at the facility per department. If this application is for an existing licensed facility, then identify the total FTE on the last day of the most recent pay period. Include only paid employees. If one employee serves in more than one position, include them in both departments by the estimated fraction of the FTE for each department.

	Employed Staff	Contractual	Total FTEs
Administration	______	______	______
Business Office	______	______	______
Medical Records & Library	______	______	______
Nursing			
R.N.	______	______	______
L.P.N.	______	______	______
C.N.A.	______	______	______
Nursing Education			
Administrative	______	______	______
Instructors	______	______	______
Clinical Laboratory			
Pathologist	______	______	______
Technicians	______	______	______
Others	______	______	______
Dietary			
Supervisory	______	______	______
Cooks & Bakers	______	______	______
Diet Aides	______	______	______
Pharmacy			
Pharmacist	______	______	______
Technicians	______	______	______
Social Services			
Social Workers	______	______	______
Social Worker Assistants	______	______	______
Restorative & Rehab PT			
PT	______	______	______
OT	______	______	______

	Employed Staff	Contractual	Total FTEs
Restorative & Rehab PT (continued)			
PTA	____________	____________	____________
OTA	____________	____________	____________
SP/SLP	____________	____________	____________
Housekeeping	____________	____________	____________
Plan Operations/Maintenance	____________	____________	____________
Laundry	____________	____________	____________
Professional Services			
Physicians	____________	____________	____________
Physicians' Assistants	____________	____________	____________
Nurse Practitioners	____________	____________	____________
Dental			
Dentist	____________	____________	____________

Other Departments

If the facility has other organized departments or other employees, please list & designate the department or the employee's job title.

Department (or Job Title)	Specialty	Employed Staff	Contractual	Total FTE

9. Physical Plant

A. Number of beds on each floor or wing:

Floor (Wing) Name	No. of Beds	Floor (Wing) Name	No. of Beds
______________	______	______________	______
______________	______	______________	______
______________	______	______________	______
______________	______	______________	______
______________	______	______________	______
______________	______	______________	______
______________	______	______________	______
______________	______	______________	______

Name of person(s) in charge of physical plant: ______________________________

Is the facility building a new addition or making remodeling changes at the present time? Yes: ☐ No: ☐

If yes, please describe project:

How will this affect the bed complement? ______________________________

Did the project require a certificate of need (CON)? Yes: ☐ No: ☐

Estimated Cost? ______________________________

a. Floor Plan

Please attach a separate listing of room numbers, number of beds in each room and their primary use. Additionally, include rooms that are licensed for beds which have been changed to something other than inpatient use and can be converted back to inpatient beds within 24 hours.

NOTE*: The Administrator should be prepared to present Certification and Licensing surveyors with a current bed count during the entrance conference of a licensure survey.*

***b.* Life Safety Code**

Please provide the following information pertaining to your Life Safety Code features:

Building Construction Type (per NFPA 101: 2012 edition): ____

If multiple construction types, indicate those here: ____

Number of Stories: __________

Medical Gas System Type (per NFPA 99: 2012 edition): ____

Generator Type (per NFPA 99: 2012 edition): ____

Fully Sprinkled: ☐ Yes ☐ No

Smoke Detection System: ☐ Yes ☐ No

NOTE*: The Administrator should be prepared to present Certification and Licensing surveyors with a digital or printed copy of the facility's Life Safety Code Plans. These plans should include items such as, but not limited to:*

- *Fire Extinguisher Location*
- *Exit Discharges/Exit Signs*
- *Fire Walls/Barriers*
- *Smoke Barriers*
- *Separation of Hazardous Areas*
- *Separation of Vertical Openings*
- *Smoke Compartment Borders and Square Footage*
- *Emergency Lighting/Egress Lighting (optional)*

State of Alaska

Department of Health

Long Term Care Facility
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: ______________________________ **Payment Type:** ______________________________

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: ____

10. 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 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 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 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: ___________________________________