State of Alaska

Department of Health

State Licensure Modification Application

Pursuant to the **AS 47.32** Licensing Statues and the regulations of the Department of Health Facilities Licensing Requirements under **7 AAC 12.615** this application is used for modification to a previously submitted initial or renewal licensure application. Complete the "Facility Demographic" section of this form and all other sections as appropriate. *Incomplete modification application will not be accepted.*

For modifications, what type of modification(s) *(check all that apply)*:

☐ Change of Location/Address ☐ Change of Ownership ☐ Change in Bed Capacity

☐ Other (brief description): _____

FACILITY DEMOGRAPHIC INFORMATION

State Licensing Number: _____ Facility Type: Select One _____

Legal Name: _____

Doing Business as: _____

Date expected for modification to occur:_____

1. CHANGE OF LOCATION/ADDRESS

Previous Physical Address: _____

City: _____ State: _____ Zip: _____

Previous Mailing Address: _____

City: _____ State: _____ Zip: _____

Primary Phone Number: _____ Secondary Phone Number: _____

Primary Fax Number: _____ Secondary Fax Number: _____

New Physical Address*: _____

City: _____ State: _____ Zip: _____

New Mailing Address: _____

City: _____ State: _____ Zip: _____

Primary Phone Number: _____ Secondary Phone Number: _____

Primary Fax Number: _____ Secondary Fax Number: _____

*Attach a copy of the new facility layout that includes identification of rooms and Life Safety Code features.

2. OWNERSHIP & ADMINISTRATION

Governmental:	◯ State	◯ Borough	◯ City/Community
Non for Profit:	◯ Church Operated/Affiliated	◯ Corporation	
Proprietary:	◯ Individual	◯ Partnership	◯ Corporation

Other (please explain): _____

Date of official change of ownership: _____

Provide as much detail as possible comparable to the original application Ownership & Administration section. When requesting a change in bed capacity, utilize the original application template and provide a copy of the Ownership/Administration section. Original application templates can be found on the Health Facilities Licensing & Certification licensure website. *Attached supporting documentation for change in ownership*.

3. CHANGE IN BED CAPACITY/STATUS

When requesting a change in bed capacity, utilize the original application template and provide a copy of the bed capacity section only. Original application templates can be found on the Health Facilities Licensing & Certification licensure website.

Type of Change: ◯ Increase Bed Capacity ◯ Decrease Bed Capacity ◯ Change in Swing-Bed Status

4. OTHER MODIFICATOINS

When requesting any modification not identified in this document, utilize the original application template, and provide of copy of the section you wish to modify. Original application templates can be found on the Health Facilities Licensing & Certification licensure website. Provide detailed information on the modification you are requesting. In addition, you may provide a description below, as well as attach the corresponding section from the original application template.

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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 full facility name, state licensing number, and exact payment amount.

State Licensing Number: _____

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

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

DEDT: 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: _____

5. 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