



# Residential Psychiatric Treatment Center (RPTC) State Licensure Application



State of Alaska- Department of Health  
Division of Health Care Services  
Health Facilities Licensing and Certification

**Pursuant to the AS 47.32 Licensing Statute and the regulations of the Department of Health Health Facilities Licensing requirements (7 AAC 10, 7 AAC 12, and 7 AAC 50).**

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. The following documentation must be submitted with your application in accordance with 7 AAC 50.030:
  - Copy of enabling legislation, charter, partnership agreement, constitution or articles of incorporation if applicant is a legal entity.
  - List of phone numbers and electronic address of each person who has ownership and management interest.
  - Administrator's references.
  - Administrator education, experience summary.
  - Proof Administrator fingerprints submitted.
  - Proof of provisional background authorization on the Administrator and all individuals living in the facility age 16 and older, excluding residents.
  - Variance request if applicable.
  - Water test results, unless the facility utilizes city water.
  - Copies of information for parents or referral and placement agencies.
  - Organizational chart.
  - Staffing Plan.
  - Operations manual including:
    - All written policies, handbooks and procedures required to operate the facility.
    - Personnel policies (to include personnel qualifications, job descriptions, and annual evaluations).
    - Any resident rules and activity schedules.
    - All facility forms.
    - Floor plan diagram including dimensions of bedrooms.



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## 1. Facility Demographics

State of Alaska Health Facilities Licensing Number: \_\_\_\_\_

Facility Name: \_\_\_\_\_

Doing Business as: \_\_\_\_\_

Facility Physical Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Facility Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Phone Number: \_\_\_\_\_ Secondary Phone Number: \_\_\_\_\_

Primary Fax Number: \_\_\_\_\_ Secondary Fax Number: \_\_\_\_\_

Generic Email (*info@abcfacility.com*): \_\_\_\_\_

## 2. Type of Business and Ownership Interest

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 of the people who own the facility)

Number	Name	Address
1.		
2.		
3.		
4.		

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

Number	Name	Business
1.		
2.		
3.		
4.		



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**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 below, as applicable.

Number	Title	Name	Address
1.			
2.			
3.			
4.			

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

**3. Administration**

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

**d. Administrator** (for initial applications, attach resume as **Exhibit I**):

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Direct Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

**e. Associate Administrator:**

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Direct Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

**f. Supervising Nurse / Director of Nursing:**

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Direct Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

**4. Specializations (check all that apply):**

- |   |  |
|---|--|
| <input type="checkbox"/> Emergency Shelter Care<br><input type="checkbox"/> Emergency Shelter Runaway Child<br><input type="checkbox"/> Care for Pregnant and Parenting Adolescents<br><input type="checkbox"/> Wilderness and Adventure Experience Program | <input type="checkbox"/> Substance Use Treatment<br><input type="checkbox"/> Supervised Transitional Living<br><input type="checkbox"/> Short Term Prematernal |
|---|--|



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## 5. Age Range, Capacity, and Individuals Served

Age Range: From \_\_\_\_ to the age of \_\_\_\_  
Capacity: \_\_\_\_\_  
Sex: Male \_\_\_\_ Female \_\_\_\_ Both \_\_\_\_

## 6. Security Level, Training Plan, and Security Plan

Please provide the security level of the facility:  Semi-secured  Semi-secured & Secured

Submit the training plan required by 7 AAC 50.820 as part of the facility's application (*Exhibit II*)

Submit a written security plan to the department as part of the facility's application for a license or a license renewal. Parts of a facility's security plan that are related to fire or emergency safety must meet the approval of the appropriate municipal or state fire safety authority, and the facility shall supply proof of the required approval to the department at the time the application is submitted per 7 AAC 50.805 (*Exhibit III*).

## 7. 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:

## 8. Accreditation (if applicable)

Is the facility fully approved by an 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: \_\_\_\_\_

*NOTE: 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. This option is not available for initial application.*



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## 9. 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.

The designee attest compliance will be maintained for all notification requirements for incidents under, AS 47.32.200 and 7 AAC 50.140 (a)&(b) and any allegations of abuse, neglect, or exploitation that must be submitted within regulatory timeframes

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) and **7 AAC 50** (Community Care Licensing).

**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.**

Printed Administrator or Designee Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Administrator or Designee: \_\_\_\_\_

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

Health Facilities Licensing & Certification  
4601 Business Park Blvd., Bldg. K,  
Anchorage, AK 99503  
Phone: (907) 334-2483 Fax: (907) 334-2682  
Email: [doh.hflc.info@alaska.gov](mailto:doh.hflc.info@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 biennial 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 name: \_\_\_\_\_

CCN and/or AK License number: \_\_\_\_\_

Was the current Administrator appointed in the past 12 months? Yes:  No:

Name of accrediting organization: \_\_\_\_\_

Date of last inspection: \_\_\_\_\_ Frequency of accreditation cycles: \_\_\_\_\_

Were any deficiencies identified during the 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 last inspection report and plan of correction MUST be submitted with the application, or the waiver will be denied\***

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### 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: \_\_\_\_\_