



**State of Alaska**  
**Department of Health**  
**Home Health Agency**  
**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*): \_\_\_\_\_



**State of Alaska**  
**Department of Health**  
**Home Health Agency**  
**State Licensure Application**



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: \_\_\_\_\_

Does the administrator/manager have responsibilities for more than one Alaska agency? Yes\*:  No:

\*If yes, list additional agencies names & license number:

Agency Name: \_\_\_\_\_ License Number: \_\_\_\_\_

Agency Name: \_\_\_\_\_ License Number: \_\_\_\_\_

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

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

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

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

Does the Director of Clinical Services have responsibilities for more than one Alaska agency? Yes\*:  No:

\*If yes, list additional agencies names & license number:

Agency Name: \_\_\_\_\_ License Number: \_\_\_\_\_

Agency Name: \_\_\_\_\_ License Number: \_\_\_\_\_

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

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

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

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



**State of Alaska**  
**Department of Health**  
**Home Health Agency**  
**State Licensure Application**



**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: \_\_\_\_\_



**State of Alaska**  
**Department of Health**  
**Home Health Agency**  
**State Licensure Application**



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: \_\_\_\_\_



**State of Alaska**  
**Department of Health**  
**Home Health Agency**  
**State Licensure Application**



**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. BRANCH OFFICES**

**Branch office** is located in the same service area as the parent agency and shares administration, supervision, and service with the parent agency on a daily basis; a branch office **is not required to be separately licensed**.

Provide the name and location of any subunits or branch offices of the hospice agency:

Name	Location	Medicare Provider Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**8. AUTHORITY & SUPERVISION**

If the hospice has established lines of authority or supervision, provide an organization chart that provides the line of authority or supervision.

If yes, attach chart and explanation as **Exhibit II**.



**State of Alaska**  
**Department of Health**  
**Home Health Agency**  
**State Licensure Application**



**9. AGENCY CONTRACTS**

Please note: SKILLED NURSING may not be contracted unless it is to cover vacations of regular staff or for specialized skills not routinely offered. SKILLED NURSING must be directly provided by the agency plus ONE OTHER RECOGNIZED SERVICE in order to qualify as a home health agency pursuant to Alaska law. If you contract SKILLED NURSING, please provide rationale. Add separate sheets if necessary

Name of Organization: \_\_\_\_\_

Address of Organization: \_\_\_\_\_

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Skilled Nursing  | <input type="checkbox"/> Speech Therapy       | <input type="checkbox"/> Medical Social Worker |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Home Health Aide      |

Name of Organization: \_\_\_\_\_

Address of Organization: \_\_\_\_\_

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Skilled Nursing  | <input type="checkbox"/> Speech Therapy       | <input type="checkbox"/> Medical Social Worker |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Home Health Aide      |

Name of Organization: \_\_\_\_\_

Address of Organization: \_\_\_\_\_

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Skilled Nursing  | <input type="checkbox"/> Speech Therapy       | <input type="checkbox"/> Medical Social Worker |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Home Health Aide      |

Name of Organization: \_\_\_\_\_

Address of Organization: \_\_\_\_\_

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Skilled Nursing  | <input type="checkbox"/> Speech Therapy       | <input type="checkbox"/> Medical Social Worker |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Home Health Aide      |



# State of Alaska

## Department of Health

### Home Health Agency

### State Licensure Application



#### 10. PERSONNEL/STAFFING

Provide full time equivalents (FTEs), part time equivalents (PTEs) & paid volunteers (PVs) for the following staffing areas. \*If you indicate vacancies, please provide a yes or no response to the “actively recruiting” and “qualified person acting” column.

	FTE	PTE	PV	Vacancies*	Actively Recruiting	Qualified Person Acting
Administration	_____	_____	_____	_____	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Medical Director	_____	_____	_____	_____	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Physician on PAC	_____	_____	_____	_____	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No
R.N.	_____	_____	_____	_____	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No
L.P.N.	_____	_____	_____	_____	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Nurse Practitioner	_____	_____	_____	_____	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Physician Assistant	_____	_____	_____	_____	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Home Health Aide	_____	_____	_____	_____	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Personal Care Attendant	_____	_____	_____	_____	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Dietitian	_____	_____	_____	_____	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Occupational Therapist	_____	_____	_____	_____	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Physical Therapist	_____	_____	_____	_____	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Speech Pathologist	_____	_____	_____	_____	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Audiologist	_____	_____	_____	_____	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Medical Social Worker	_____	_____	_____	_____	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Health Care Professionals	_____	_____	_____	_____	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Non-Health Care Professional	_____	_____	_____	_____	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>TOTAL</b>	_____	_____	_____	_____		

#### 11. GEOGRAPHICAL AREA SERVED

Please describe the geographical area served by the agency. Provide specific areas or regions. The Department will not accept descriptions such as “Southeast Alaska” or “South Central Alaska”:



**State of Alaska**  
**Department of Health**  
**Home Health Agency**  
**State Licensure Application**



**12. CLIENT CENSUS INFORMATION (if this is an initial application, skip this section)**

Provide number of clients (unduplicated admissions) served during the last full calendar year (from January 1 through December 31): \_\_\_\_\_

Number of clients served in all age categories below for the last full calendar year (as indicated above):

	Under 5	5-17	18-44	45-64	65-74	Over 75	Total
Males	_____	_____	_____	_____	_____	_____	_____
Females	_____	_____	_____	_____	_____	_____	_____
Total	_____	_____	_____	_____	_____	_____	_____

During the time period indicated above, provide the following information:

Admitted	_____	Discharged	_____	Clients Terminated	_____
Deceased	_____	Respite Days	_____	Acute Care Days	_____
Highest Client Count	_____	Lowest Client Count	_____	Average Client Count	_____

**13. TYPE OF HOME HEALTH AFFILIATION**

- Hospital   
  Skilled Nursing Facility   
  Hospice Agency   
  Free Standing Home Health Agency  
 Other: \_\_\_\_\_

**14. SOURCE OF INCOME**

Provide the information as requested below for source(s) of income:

Source(s)	Percentage	Income
Medicare Part A	_____	_____
Medicare Part B	_____	_____
Medicaid	_____	_____
Third Party Payers (Health Insurance, VA, Workers Comp, ect.)	_____	_____
Fees from Patients	_____	_____
Other (Grants, Contributions, Bequests, Fund Raising, ect)	_____	_____
<b>TOTAL</b>	<b>100%</b>	_____





**State of Alaska**  
**Department of Health**  
**Home Health Agency**  
**State Licensure Application**



**15. SERVICES (attach additional sheet if more space is needed)**

Service Category	Services Provided		Name of Outside Contractor
Physician Services	<input type="checkbox"/> Direct	<input type="checkbox"/> Contract	_____
Nursing Services	<input type="checkbox"/> Direct	<input type="checkbox"/> Contract	_____
Social Services	<input type="checkbox"/> Direct	<input type="checkbox"/> Contract	_____
Pastoral Counseling	<input type="checkbox"/> Direct	<input type="checkbox"/> Contract	_____
Bereavement Counseling	<input type="checkbox"/> Direct	<input type="checkbox"/> Contract	_____
Dietary Counseling	<input type="checkbox"/> Direct	<input type="checkbox"/> Contract	_____
Short-Term Inpatient (respite)	<input type="checkbox"/> Direct	<input type="checkbox"/> Contract	_____
Shor-Term Inpatient (acute)	<input type="checkbox"/> Direct	<input type="checkbox"/> Contract	_____
Home Aide Service	<input type="checkbox"/> Direct	<input type="checkbox"/> Contract	_____
PCA Services	<input type="checkbox"/> Direct	<input type="checkbox"/> Contract	_____
Physical Therapy	<input type="checkbox"/> Direct	<input type="checkbox"/> Contract	_____
Occupational Therapy	<input type="checkbox"/> Direct	<input type="checkbox"/> Contract	_____
Speech/Language Pathology	<input type="checkbox"/> Direct	<input type="checkbox"/> Contract	_____
Medical Supplies	<input type="checkbox"/> Direct	<input type="checkbox"/> Contract	_____
Drugs & Biologicals	<input type="checkbox"/> Direct	<input type="checkbox"/> Contract	_____
Medical Equipment	<input type="checkbox"/> Direct	<input type="checkbox"/> Contract	_____
Personal Care	<input type="checkbox"/> Direct	<input type="checkbox"/> Contract	_____
IV Infusion	<input type="checkbox"/> Direct	<input type="checkbox"/> Contract	_____
Other	<input type="checkbox"/> Direct	<input type="checkbox"/> Contract	_____
Other	<input type="checkbox"/> Direct	<input type="checkbox"/> Contract	_____
Other	<input type="checkbox"/> Direct	<input type="checkbox"/> Contract	_____

Short-Term inpatient care can only be provided in a licensed hospital or skilled nursing facility.  
 Contracts must be available for review by the Department staff at the time of licensure survey.



**State of Alaska**  
**Department of Health**  
**Home Health Agency**  
**State Licensure Application**



**16. SCOPE OF SERVICE**

**7 AAC 12.500. Scope.** A public or private entity that is primarily engaged in the provision of skilled nursing care and therapeutic services, but not the treatment of mental illness, in a patient's home is a home health agency, and must comply with **7 AAC 12.500 – 7 AAC 12.590**.

**7 AAC 12.505. Home health agency services.**

- (a) A home health agency must provide skilled nursing services and at least one of the following additional services:
  - (1) physical therapy;
  - (2) occupational therapy;
  - (3) speech therapy; or
  - (4) home health aide services.
  
- (b) A home health agency may provide additional services designed to maintain, improve, or restore a physical or mental condition. Additional services must be provided in accordance with generally accepted professional standards and identified in a plan of care established under **7 AAC 12.513**. Additional services may include
  - (1) nursing care under the supervision of a registered nurse;
  - (2) physical, occupational, speech, or respiratory therapy;
  - (3) medical social services;
  - (4) nutrition counseling;
  - (5) home health aide services;
  - (6) personal care services; and
  - (7) medical supplies, other than drugs and biologicals, and the use of medical appliances.

**DOES THE HOME HEALTH AGENCY MEET ALL  
 THE ABOVE SCOPE OF SERVICE REQUIREMENTS?**

Yes       No\*

*\*If not, please provided an explanation:*



**State of Alaska**  
**Department of Health**  
**Home Health Agency**  
**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 [dhes.hflc@alaska.gov](mailto:dhes.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: \_\_\_\_\_



**State of Alaska**  
**Department of Health**  
**Home Health Agency**  
**State Licensure Application**



**17. 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](mailto:dhcs.hflc@alaska.gov)



**State of Alaska**  
**Department of Health**  
**Home Health Agency**  
**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 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 last inspection report and plan of correction **MUST**  
be submitted with the application or the waiver will be denied\*\*\***

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