State of Alaska

Department of Health - Division of Healthcare Services
Health Facilities Licensing and Certification

Hospital
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.

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

Name:_____ Title:_____

Direct Phone:_____ Fax:_____

Email:_____

Medical Director / Director of Clinical Services (*for initial applications, attach resume as **Exhibit II***)**:**

Name:_____ Title:_____

Direct Phone:_____ Fax:_____

Email:_____

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

Name:_____ Title:_____

Direct Phone:_____ Fax:_____

Email:_____

3. ACCREDITATION (if applicable)

Is the facility 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)

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	Address
1.		
2.		
3.		
4.		

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:_____

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

d. List names and addresses of each shareholder holding more than 5% of shares OR ownership.

Number	Name	State of Residence	Percent of Shares
1.			
2.			
3.			
4.			

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 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 III**: 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 in-patient care, including children's cribs. (Exclude bassinets in maternity department nurseries but count those in pediatric departments and in premature nurseries if not located in the maternity department. Exclude labor and recovery beds.)

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

Emergency capacity: Number of beds that can reasonably be added to the bed complement in periods of unusually high occupancy. Include the number of beds that can reasonably be added to the bed capacity in the case of an area wide disaster.

Number of beds for patients (exclude beds in emergency departments, labor and recovery rooms etc.)

	NUMBER OF BEDS
Total Bed Complement	_____
Bed Capacity (number of beds applying for)	_____
Emergency Capacity	_____
Long Term Care (swing beds / included in total bed capacity)	_____
Internal Medicine	_____
General Surgical	_____
Gynecological and Obstetrics	_____

Intensive Care _____

Coronary Care _____

Acute Mental Illness _____

Neonatal Intensive Care Level II _____

Neonatal Intensive Care Level III _____

Pediatrics _____

Long Term Acute Care _____

Restorative/Rehabilitation _____

Other (Please Explain):_____ _____

TOTAL:_____

Number of bassinets in Maternity department nurseries _____

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

Number of patient care days (exclusive of newborn) rendered in the last calendar or fiscal year?_____

8. DEPARTMENT AND SERVICES

a. Dietary Department

Name of person in charge: _____ Title: _____

Current Alaska License Number: _____

Has the hospital arranged for the service of a consultant dietitian if no full-time or par-time dietician is employed?

Yes: ☐ No: ☐

b. Radiological Department

Are general radiological services provided in the hospital? Yes: ☐ No: ☐

If no, provide name of hospital, clinic or other facility providing this service:

_____

Does hospital policy make x-ray film of chest part of routine admission procedure? Yes: ☐ No: ☐

Types of Services:

Radiological **Yes: ☐** **No: ☐**

Regular	No. of Radiograph Units: _____	MA rating of each unit: _____
Portable	No. of Radiograph Units: _____	MA rating of each unit: _____
Dental	No. of Radiograph Units: _____	MA rating of each unit: _____
Other	No. of Radiograph Units: _____	MA rating of each unit: _____

Fluoroscopic Yes: ☐ No: ☐

Radioactive Isotopes Yes: ☐ No: ☐

Interventional Yes: ☐ No: ☐

Therapeutic **Yes: ☐** **No: ☐**

Deep Therapy KVP rating of unit: _____ Yes: ☐ No: ☐

Intermediate KVP rating of unit: _____ Yes: ☐ No: ☐

Superficial KVP rating of unit: _____ Yes: ☐ No: ☐

Radium (Randon) Therapy Yes: ☐ No: ☐

Radioactive Isotopes Yes: ☐ No: ☐

Name of Physician in charge of service:_____

Physician Board Certified: Yes: ☐ No: ☐ Current AK License No._____

Full Time: ☐ Part Time: ☐ On-Call: ☐ days/week:_____ days/month _____

If the hospital is not served by a full-time radiologist, or regularly visited by a part-time radiologist, is the radiological service supervised by a member of the medical staff? Yes: ☐ No: ☐

Name of Physician in charge of service:_____

Physician Board Certified: Yes: ☐ No: ☐ Current AK License No,_____

Does the hospital radiology dept. utilize tele-radiology with a radiologist outside of Alaska? Yes: ☐ No: ☐

Name of Physician in charge of service:_____

Physician Board Certified: Yes: ☐ No: ☐ Current AK License No._____

c. Clinical Laboratory Department

Is the laboratory service provided in the hospital? CLIA# _____ Yes: ☐ No: ☐

If no, provide name of hospital, clinic or other facility providing this service:

_____

Types of Services Provided (check all that apply):

☐ Tissue Pathology ☐ Clinical Pathology ☐ Radiobioassay

☐ Immunohematology ☐ Histocompatibility ☐ Blood bank

☐ Diagnostic Immunology ☐ Clinical Cytogenetics ☐ Photography

☐ Autopsy ☐ Microbiology ☐ Basal Metabolism

☐ Hematology ☐ Chemistry

☐ Other (specify):_____

Name of Physician in charge of service:_____

Physician Board Certified: Yes: ☐ No: ☐ Current AK License No. _____

Full Time: ☐ Part Time: ☐ On-Call: ☐ days/week: _____ days/month _____

If the hospital is not served by a full-time pathologist, or regularly visited by a part-time pathologist, is theclinical laboratory service supervised by a member of the medical staff? Yes: ☐ No: ☐

Name of Physician in charge of service:_____

Physician Board Certified: Yes: ☐ No: ☐ Current AK License No.:_____

d. Anesthesiology Department

Name of Physician in charge of service:_____

Physician Board Certified: Yes: ☐ No: ☐ Current AK License No. _____

Full Time: ☐ Part Time: ☐ On-Call: ☐ days/week: _____ days/month _____

If the hospital does not have an organized anesthesia service, is the anesthesia department service supervised by a member of the medical staff? Yes: ☐ No: ☐

Who usually gives anesthesia? M.D: ☐ Nurse Anesthetist: ☐ Other: ☐:_____

Are these individuals usually hospital employees? Yes: ☐ No: ☐

e. Outpatient Department

Does the hospital have an organized outpatient department(s)? Yes: ☐ No: ☐

List organized clinics conducted at the facility (e.g., STD, Cancer, Pre-Natal, Orthopedics, etc.):

If the hospital has no organized outpatient department, please check all services provided to outpatients:

☐ Laboratory Examination ☐ Emergency Services ☐ X-Ray Examinations

☐ X-Ray or Radium Therapy ☐ Outpatient Surgical Service

☐ Other(s): _____

f. Medical Department

Does the hospital have an organized medical department? Yes: ☐ No: ☐

Name of Physician in charge of service:_____

Physician Board Certified: Yes: ☐ No: ☐ Current AK License No. _____

Full Time: ☐ Part Time: ☐ On-Call: ☐ days/week:_____ days/month _____

g. Surgical Department

Does the hospital have an organized surgical department? Yes: ☐ No: ☐

Name of Physician in charge of service:_____

Physician Board Certified: Yes: ☐ No: ☐ Current AK License No._____

Full Time: ☐ Part Time: ☐ On-Call: ☐ days/week: _____days/month _____

h. Restorative & Rehabilitation Department

Does the hospital have an organized rehabilitation department? Yes: ☐ No: ☐

Types of Services Provided:

☐ Physical Therapy ☐ Vocational Counseling ☐ Dietary

☐ Occupational Therapy ☐ Therapeutic Recreation ☐ Psychological

☐ Speech Pathology ☐ Social Services ☐ Other (specify below):

Name of person in charge of service:_____

Professional Specialty: _____ Current AK License No.:_____

Full Time: ☐ Part Time: ☐ On-Call: ☐ days/week: _____ days/month:_____

i. Pathology Department

Does the hospital have an organized pathology department? *Yes: ☐ **No: ☐

Does the hospital have a tissue committee made of medical staff? Yes: ☐ No: ☐

Are anatomical pathological services provided? Yes: ☐ No: ☐

**If no to the above, list the hospital, clinic or other facility providing these services:_____

_____

*If Yes, Name of Physician in charge of service:_____

Physician Board Certified: Yes: ☐ No: ☐ Current AK License No. _____

Full Time: ☐ Part Time: ☐ On-Call: ☐ days/week: _____ days/month _____

j. Intensive Care Department

Does the hospital have an organized intensive care department? Yes: ☐ No: ☐

Name of Physician in charge of service:_____

Physician Board Certified: Yes: ☐ No: ☐ Current AK License No. _____

Full Time: ☐ Part Time: ☐ On-Call: ☐ days/week: _____ days/month _____

k. Dental Department

Does the hospital have an organized dental department? Yes: ☐ No: ☐

Name of Physician in charge of service:_____

Physician Board Certified: Yes: ☐ No: ☐ Current AK License No. _____

Full Time: ☐ Part Time: ☐ On-Call: ☐ days/week: _____ days/month _____

l. Social Service Department

Does the hospital have an organized social services department? Yes: ☐ No: ☐

Name of person in charge of service: _____

Current AK License No. _____

Full Time: ☐ Part Time: ☐ On-Call: ☐ days/week: _____ days/month _____

m. Medical Records Department

Does the hospital have an organized medical records department? Yes: ☐ No: ☐

Name of person in charge of service:_____

Full Time: ☐ Part Time: ☐ On-Call: ☐ days/week: _____ days/month _____

n. Perinatal Department

Does the hospital have an organized perinatal department? Yes: ☐ No: ☐

Name of person in charge of service:_____

Full Time: ☐ Part Time: ☐ On-Call: ☐ days/week: _____ days/month _____

o. Emergency Department

Does the hospital have an organized emergency department? Yes: ☐ No: ☐

Name of person in charge of service: _____

Full Time: ☐ Part Time: ☐ On-Call: ☐ days/week: _____ days/month _____

p. Respiratory Therapy Department

Does the hospital have an organized respiratory therapy department? Yes: ☐ No: ☐

Name of person in charge of service: _____

Full Time: ☐ Part Time: ☐ On-Call: ☐ days/week: _____ days/month _____

q. Psychiatric Department

Does the hospital have an organized psychiatric department? Yes: ☐ No: ☐

Name of person in charge of service: _____

Full Time: ☐ Part Time: ☐ On-Call: ☐ days/week: _____ days/month _____

r. Substance Abuse Department

Does the hospital have an organized substance abuse department? Yes: ☐ No: ☐

Name of person in charge of service: _____

Full Time: ☐ Part Time: ☐ On-Call: ☐ days/week: _____ days/month _____

s. Nuclear Medicine Department

Does the hospital have an organized nuclear medicine department? Yes: ☐ No: ☐

Name of person in charge of service: _____

Full Time: ☐ Part Time: ☐ On-Call: ☐ days/week: _____ days/month _____

t. Coronary Care Department

Does the hospital have an organized coronary care department? Yes: ☐ No: ☐

Name of person in charge of service: _____

Full Time: ☐ Part Time: ☐ On-Call: ☐ days/week: _____ days/month _____

u. Infection Control Department

Does the hospital have an organized infection control department? Yes: ☐ No: ☐

Name of person in charge of service: _____

Full Time: ☐ Part Time: ☐ On-Call: ☐ days/week: _____ days/month _____

v. Quality Improvement Department

Does the hospital have an organized quality department? Yes: ☐ No: ☐

Name of person in charge of service: _____

Full Time: ☐ Part Time: ☐ On-Call: ☐ days/week: _____ days/month _____

w. Risk Management Department

Does the hospital have an organized risk management department? Yes: ☐ No: ☐

Name of person in charge of service: _____

Full Time: ☐ Part Time: ☐ On-Call: ☐ days/week: _____ days/month _____

9. PERSONNEL

a. Medical Staff

Medical Staff organized with written by-laws, officer, regular meetings, and written minutes?

Yes: ☐ No: ☐

To what staff group do dentist belong? _____

b. Personnel by Department

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.

Department	Employed Staff	Contractual	Total FTEs
Administration			
Business Office			
Medical Records & Library			
Nursing – R.N.			
Nursing – L.P.N.			
Nursing – C.N.A.			
Nursing – Others			
Nursing Education – Administrative			
Nursing Education – Instructors			
X-Ray & Radiology – Radiologist			
X-Ray & Radiology – Technicians			
X-Ray & Radiology – Others			
Clinical Laboratory – Pathologist			
Clinical Laboratory – Technicians			
Clinical Laboratory – Others			
Dietary – Supervisory			
Dietary – Cooks & Bakers			
Dietary – Diet Aids			

Department	Employed Staff	Contractual	Total FTEs
Pharmacy – Pharmacist			
Pharmacy – Technicians			
Social Services – Social Workers			
Social Services – Social Worker Assistant			
Restorative & Rehab – PT			
Restorative & Rehab – Ot			
Restorative & Rehab – PTA			
Restorative & Rehab – OTA			
Restorative & Rehab – SP/SLP			
Housekeeping			
Plan Operations/Maintenance			
Professional Services – Physicians			
Professional Services – Physician Assistant			
Professional Services – Nurse Practitioner			
Dental – Dentist			

c. 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 FTEs

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

10. 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? _____

b. 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.*

c. Life Safety Code

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

Building Construction Type (per NFPA 101: 2012 edition): Select One

If multiple construction types, indicate those here: _____

Number of Stories: _____

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

Generator Type (per NFPA 99: 2012 edition): Select One

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)*

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Department of Health - Division of Healthcare Services
Health Facilities Licensing and Certification

Hospital
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: Select One _____ **Payment Type:** Select One _____

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:_____

11. 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.

Printed 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.g

State of Alaska

Department of Health - Division of Healthcare Services
Health Facilities Licensing and Certification

Hospital
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: Select One _____ 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:_____