State of Alaska

Department of Health

Rural Health Clinic/Frontier Extended Stay Clinic 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 to 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)

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.		

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 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 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.

Does the facility have designated space and beds for treatment of RHC/FESC patients? Yes:☐ No:☐

Are any patient beds located in rooms below ground level? Yes: ☐ No: ☐ If yes, how many? __________

	Number of Beds
Bed Capacity* (number of RHC/FESC beds applying for)	______________________
Emergency Capacity	______________________

**NOTE: RHC/FESC may not have more than 4 beds*

8. OPERATION TYPE

The clinic currently operates as a (check all that apply):

☐ Rural Health Clinic ☐ Federally Qualified Care Center ☐ Community Health Center

☐ Physician Clinic ☐ Frontier Extended Stay Clinic

☐ Other (specify):______________________________

9. GEOGRRAPHIC SERVICE AREA

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”:

10. INITIAL APPLICANTS ONLY

- **a.** Provide a copy of the facility's plan for the delivery of health services within the service area as ***Exhibit II***.
- **b.** Provide a copy of the facility's plan for staffing when a patient is admitted for care or services in the RHC/ FESC as ***Exhibit III***.
- **c.** Provide a copy of the facility's emergency services plan that coordinates the provisions of emergency medical services in the service area as ***Exhibit IV***.
- **d.** Provide a description of the clinic's volume capacity as ***Exhibit V***.

11. RHC/FESC PATIENTS (License Renewal Only)

If this application is for renewal of the clinic's RHC/FESC license, please provide the number of patients admitted during the previous 12 months for extended stay including:

- **a. The number of patients admitted for an extended stay described in 7 AAC 12.450(a)(2)(A);**
  (A) are seriously ill, critically ill, or seriously injured and who cannot be transferred to a general acute care hospital, rural primary care hospital, or critical access hospital because of adverse weather conditions, unavailability of a transport vehicle, or another similar unavoidable circumstance;

  Number of Patients:______________________ Average Length of Stay per Patient:_________________________

b. The number of patients admitted for an extended stay described in 7 AAC 12.450(a)(2)(B);
(B) are seriously ill, critically ill, or seriously injured and require transfer to a general acute care hospital, rural primary care hospital, or critical access hospital but exercise the right, against the medical advice of the attending practitioner, not to be transferred, and elect to receive extended stay services appropriate to manage the individual's illness or injuries to the extent possible within the clinic's capability;

Number of Patients:______________________ Average Length of Stay per Patient:_________________________

c. The number of patients admitted for monitoring and observation described in 7 AAC 12.450(a)(2)(C);
(C) are not in obvious need of medical transport but require an extended stay for monitoring and observation.

Number of Patients:______________________ Average Length of Stay per Patient:_________________________

NOTE: Federal rules require that patients who receive extended stay for monitoring and observation may not exceed 48 hours.

Does the facility agree to limit the inpatient length of stay for monitoring and observation to 48 hours following Rural Health Clinic/Frontier Extended Stay Clinic certification?

Yes:☐ No:☐

12. PHYSICIAN RESPONSIBILITIES

Initial Applicants Only: If this is an initial application, please provide a copy of the facility's plan that demonstrates how each physician's responsibilities will be accomplished, including record reviews, policy reviews, review of services provided, supervision, and medical direction, OR

Renewal Applicants Only: If the facility's plan submitted in the initial or subsequent applications has been updated to reflect any changes since the last plan was submitted, please provide a copy of the updated plan.

Please submit the facility's plan as Exhibit VI.

13. COMPLIANCE

Does the facility meet, or intend to meet the requirements for licensure and Medicare certification as a Rural Health Clinic/Frontier Extended Stay Clinic?

Yes:☐ No:☐

*If the facility does not now meet licensure requirements as a Rural Health Clinic/Frontier Extended Stay Clinic, please indicate the date the facility will be in compliance.

Date facility will be in compliance:____

Explanation of current non-compliance:

14. FLOOR PLAN

Please attach a separate floor plan showing each floor of the building and each room, including the location of FESC beds. ***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.*

Please submit the facility's plan as Exhibit VII

15. LOCATION

The facility is located in a rural area of no more than 15,000 residents based on calculations of the United States Bureau of Census.

Yes:☐ No:☐

Please indicated in mileage to nearest hospital: Air:_________________ Highway*:__________________

*If by highway, indicated type of road: Primary: ☐ Secondary: ☐

Please indicated (in hours) travel time to nearest hospital: Air Hours:___________ Highway Hours:_____________

16. SERVICES

Service Category	Services Provided		Name of Outside Contractor
Emergency Care*	☐ Direct	☐ Contract	______________________
Medical*	☐ Direct	☐ Contract	______________________
Psychiatric Therapy	☐ Direct	☐ Contract	______________________
Medical Records	☐ Direct	☐ Contract	______________________
Laboratory*	☐ Direct	☐Contract	______________________
Nursing	☐ Direct	☐ Contract	______________________
Dietary/Food Service	☐ Direct	☐ Contract	______________________
Physical Therapy	☐ Direct	☐ Contract	______________________
Occupational Therapy	☐ Direct	☐ Contract	______________________
Respiratory Therapy	☐ Direct	☐ Contract	______________________
Outpatient	☐ Direct	☐ Contract	______________________
Radiology*	☐ Direct	☐ Contract	______________________
Social Services	☐ Direct	☐ Contract	______________________
Pharmacy	☐ Direct	☐ Contract	______________________

Laundry ☐ Direct ☐ Contract ____________________

Extended Stay Medical Transport* ☐ Direct ☐ Contract ____________________

Extended Stay patients for monitoring/obs. ☐ Direct ☐ Contract ____________________

**Services required by regulation.*

17. 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.

Department	Employed Staff	Contractual	Total FTEs
Administration			
Business Office			
Medical Records			
Nursing – R.N.			
Nursing – L.P.N.			
Nursing – C.N.A.			
X-Ray & Radiology – Radiology			
X-Ray & Radiology – Technicians			
Clinical Laboratory – Pathologist			
Clinical Laboratory – Technicians			
Pharmacy – Pharmacist			
Pharmacy – Technicians			
Social Services – Social Workers			
Social Services – Social Worker Assistants			
Housekeeping			
Plan Operations/Maintenance			
Laundry			
Professional Services – Physicians			
Professional Services – Physician's Assistants			
Professional Services – Advance Nurse Practitioners			
Dental – Dentist			

18. Other Departments

If the facility has other organized departments or other employees not provided under the categories above, please list & designate the department or the employee's job title.

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

19. RURAL HEALTH ACCESS TO CARE (Initial Applications Only)

If this is an application for initial licensure for conversion to a frontier extended stay clinic, please attach an Explanation (Exhibit VIII) of how conversion will promote regionalization of rural health services and improve access to hospital care and other health services in the community you serve.

20. OUTPATIENT CLINICS

Does the RHC/FESC have any outpatient clinics, either freestanding or as part of the facility, that are considered a unit (department) of the clinic?

Yes:☐ No:☐

21. RADIOLOGY TELEMEDICINE

Does the facility utilize tele-radiology with a radiologist outside the State of Alaska? Yes:☐ No:☐

If yes, what is the radiologist's name?____

Current Alaska License Number: ____________________________________

22. OUTREACH

Does the facility have outreach services? Yes:☐ No:☐

Please describe below:

23. ADDITIONAL COMMENTS

Provide any additional comments or information you feel will contribute to the Department's decision related to an initial or renewal of the license.

State of Alaska

Department of Health

Rural Health Clinic/Frontier Extended Stay Clinic 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:____

24. 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 of Alaska

Department of Health

Rural Health Clinic/Frontier Extended Stay Clinic
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 referto **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:____________________________