INSTRUCTIONS
FOR COMPLETING AN APPLICATION FOR LICENSE TO CONDUCT A HOSPITAL OR RELATED INSTITUTION

Please read these instructions carefully and complete this application in full. This application must be completed either in ink or typed.

SECTION I. NAME AND LOCATION.

Please complete all requested information. If facility/agency/institution is also seeking Medicare certification, all the information recorded in this Section MUST AGREE with the corresponding information as it appears on all MEDICARE DOCUMENTS (i.e., CMS-855).

Mailing address is the address to which **all** correspondence will be mailed.

Include the email address and name for the facility's contact person.

SECTION II. CLASSIFICATION TYPE.

Complete as applicable. Please remember a separate application must be completed for each facility license type. Check only one Home Health license class type (Box D), and all services presently licensed or services that are being requested in box below.

SECTION III. OWNERSHIP TYPE.

It is most important and must be completed. The institution will either be one (1) of the following Ownership Types: **PUBLIC** (State, County or City) or **PRIVATE** (Sole Proprietorship, Partnership (all types) and **FOR SECTIONS IV, V OR VI, only complete 1. This should correspond to ownership type selected in Section III.**

SECTION IV. Please list the name and title of individual who is the head of the governmental department having jurisdiction over the facility. Only complete this Section if you checked State, County or City in Section III.

SECTION V. Please list the name of the sole proprietor of the facility if you checked Sole Proprietorship in Section III.

SECTION VI. Please attach a list with the names and addresses of partners, if you checked Partnership in Section III.

SECTION VII. Please attach a list of the Board of Directors, Governing Body or Committee of the Whole. This list should include names, addresses and phone numbers.

SECTION VIII. FACILITY OWNERSHIP INFORMATION.

Please identify the entity/owner reflected in Section III, Ownership Type. Please do not record the owner of the building.

SECTION IX. FACILITY MANAGEMENT.

Respond YES or NO to question. If responded with a YES, please supply the information requested for the entity who the contract is with.

SECTION X. FISCAL YEAR ENDING DATE.

Complete this section with the **Month** and **Day** of your facility's fiscal year end.

SECTION XI. GENERAL.

This section is completed for all facility/agency/institution types that have licensed beds.

SECTION XII. ACCREDITED/DEEMED STATUS.

Complete this Section only if this application is completed due to a **Change of Ownership (CHOW)**.

Respond YES or NO to question. If responded YES, please supply the name of Accrediting Organization (AO) and whether AO grants deemed status. If AO grants deemed status, please provide documentation from AO of deemed status.

Health Facility Services/Arkansas Department of Health may have conducted your facility/agency/institution's Medicare certification survey. Health Facility Services is not an Accredited Organization.

SECTION XIII. ADMINISTRATOR NAME.

Complete this section with the name of the individual responsible for the administration of the institution.

SECTION XIV. CERTIFICATION AND VERIFICATION.

This license application must be signed by the following person(s) dependent upon the information reported in Section III. Ownership Type.

This Licensure Application is a legal document and will not be accepted if an unauthorized person(s) have/has signed and could possibly be returned for correct signature which will delay the issuance of license. Please use the table below to determine the person(s) authorized to sign.

MANAGEMENT AND OWNERSHIP TYPE	PERSON(S) AUTHORIZED TO SIGN
State	Person who is the head of the government department having jurisdiction over healthcare facility or their duly authorized representative*.
County	Person who is the head of the government department having jurisdiction over healthcare facility or their duly authorized representative*.
City	Person who is the head of the government department having jurisdiction over healthcare facility or their duly authorized representative*.
Sole Proprietorship	Owner or their duly authorized representative*.
Partnership (**all types**)	Each Partner or their duly authorized representative*. (Types: General Partnership, Limited Partnership, Limited Liability Partnership or Limited Liability Limited Partnership)
Corporation/Company (**all types**)	Two Officers of the Board or their duly authorized representative*. (Types: Incorporated, Non-Profit Corporation, Limited Liability Company)

***IF SOMEONE OTHER THAN THE ABOVE IS AUTHORIZED TO SIGN IN THEIR BEHALF, SUCH AUTHORIZATION MUST BE IN WRITING, NOTARIZED, AND ATTACHED TO THIS APPLICATION.**

THIS APPLICATION IS NOT VALID UNLESS IT IS NOTARIZED.

ADDENDUM

For Hospitals, Hospices and Home Health Agencies only. There should be an ADDENDUM attached to the application that must be completed either in ink or typed.

LICENSURE FEE

A check or money order for the required license fee made payable to the Department of Health must accompany this submission. This fee is computed as follows:

1.	Hospital	$6.00 per bed
2.	Outpatient Surgery Center	$1,000.00 per facility
3.	Recuperation Center	$275.00 per hospital-based facility $2,000.00 per free-standing facility
4.	Alcohol and Drug Abuse	$75.00 per hospital-based facility $1,000.00 per free-standing facility
5.	Outpatient Psychiatric Center	$75.00 per hospital-based facility $1,000.00 per free-standing facility
6.	Infirmary	$100.00 per facility
7.	Home Health Agency	$1,000.00 per parent agency
8.	Hospices or Hospice Care	$500.00 per facility
9.	In Vitro Fertilization Clinic	$1,000.00 per facility
10.	Free-Standing Birthing Facility	$1,000.00 per facility
11.	Private Care Agency	$1,000.00 per facility
12.	Rural Emergency Hospital	$500.00 per facility

All licenses expire at midnight on December 31 of the calendar year in which they are issued.

SUBMIT TO

The completed notarized application form, along with your check in the correct amount payable to the Arkansas Department of Health, is to be addressed to:

Health Facility Services
Arkansas Department of Health
5800 West Tenth, Suite 400
Little Rock, AR 72204-1704
(501) 661-2201

Thank you for your cooperation and please let us know if you have any questions.

CHECKLIST FOR LICENSE APPLICATION BEFORE SUBMISSION

Prior to mailing:

1. Check that all applicable sections of licensure application have been completed.

2. Either complete Section IV or Section V or Section VI. Only complete Section that corresponds to ownership type listed in Section III.

3. Make sure license application has correct signatures. Only person(s) authorized to sign listed in table on page 2 (Section XIV) of these instructions must sign the licensure application. **Licensure Applications will not be accepted and possibly returned if unauthorized person(s) have signed this legal document. This will delay the issuance of your license.**

4. Make sure licensure application has been notarized. **Licensure Applications will not be accepted and possibly returned if not notarized. This will delay the issuance of your license.**

5. Make sure a duplicate copy of the licensure application has been made for your files. If this office contacts you in order to obtain revisions/corrections to your submitted licensure application, you must use your copy. **This office will not provide a copy.**

6. Make sure the following is submitted with the licensure application:

   a. Notarized licensure application;
   b. List of Board of Directors, Governing Board or Committee of the Whole with addresses and phone numbers;
   c. If applicable, application addendums;
   d. If applicable, documentation from Accrediting Organization of deemed status;
   e. If applicable, list of partners;
   f. Check, payable to Department of Health.