

Application for License to Operate a Health Facility or Service

OIG 001 – June 2014 Edition

I. TYPE OF APPLICATION

(Write or type an X next to all that apply.)

- Initial Licensure Change of Name
 Annual Re-licensure Change of Location
 Add Location/Satellite/Service Change of Ownership

II. TYPE OF FACILITY OR SERVICE (Check the facility or service for which you are applying.)

- | | |
|---|--|
| <input type="checkbox"/> Adult Day Health Care Program (DHC) | <input type="checkbox"/> Network (NET) |
| <input type="checkbox"/> Adult Day Health Care Program (Nursing Services) | <input type="checkbox"/> Nursing Pool (NP) |
| <input type="checkbox"/> Ambulatory Care Clinic (ACC) | <input type="checkbox"/> Outpatient Health Care Center (OHCC) |
| <input type="checkbox"/> Ambulatory Surgical Center (ASC) | <input type="checkbox"/> Prescribed Pediatric Extended Care Service (PPEC) |
| <input type="checkbox"/> Community Mental Health Center (CMHC) | <input type="checkbox"/> Primary Care Center or Satellite (PCC) |
| <input type="checkbox"/> Freestanding (Alternative) Birth Center (ABC) | <input type="checkbox"/> Rehabilitation Agency (Outpatient) (REH) |
| <input type="checkbox"/> Health Maintenance Organization (HMO) | <input type="checkbox"/> Rural Health Clinic (RHC) |
| <input type="checkbox"/> Limited Services Clinic (LSC) | |

III. IDENTIFICATION

License Number _____
(Do not fill in License Number if this is an initial application for licensure)

Name of Facility _____

Physical Location of Facility _____
(Street) (City)

(County) (State) (Zip Code)

Mailing Address _____
(If different from above) (Street) (City)

(County) (State) (Zip Code)

Telephone Number _____

Email Address _____
(Primary contact for correspondence)

Administrator Name _____

Date facility began operating at current address _____

Date facility began operating under current owner _____

For Office Use Only: Check # _____ Amount _____

Instructions for Community Mental Health Centers, Networks, and Primary Care Centers:

Initial license application: Under Section A, for additional locations/satellites other than the primary location listed on the previous page, please check the box under "Additional Location or Satellite Requested" for the appropriate level of care. For each location, please complete Section B.

Re-licensure application: Under Section A, report the number of existing locations/satellites under "Number of Locations or Satellites, Not Including Primary Location". If adding a location, check the appropriate box under "Additional Location or Satellite Requested", and complete Section B. Provide an attachment to this application as requested under Section C, if needed.

Addition of Location/Satellite application: Under Section A, report the number of existing locations/satellites under the "Number of Locations or Satellites, Not Including Primary Location", then check the box marked "Additional Location or Satellite Requested". Under Section B, complete the location information for each additional location/satellite.

A.	NUMBER OF LOCATIONS OR SATELLITES, NOT INCLUDING PRIMARY LOCATION	ADDITIONAL LOCATION OR SATELLITE REQUESTED
Community Mental Health Center (CMHC)	_____	<input type="checkbox"/>
Network (NET)	_____	<input type="checkbox"/>
Primary Care Center or Satellite (PCC)	_____	<input type="checkbox"/>

B. Additional Location Information: (If adding more than one location/satellite, attach to this application the same information as required below for each location.)

Name of Facility _____

Physical Location of Facility _____
(Street) (City)

_____ (County) (State) (Zip Code)

Telephone number _____
 (Include Area Code)

Administrator _____

If this is an additional Community Mental Health Center location, detail what services will be provided at the new location: _____

C. For licensure renewals and addition of location/satellites only: Provide a detailed list of each existing location/satellite, not including the primary location, as an attachment to this application. The listing should include the same information requested in part B.

IV. CONTROL (Check one in each column.)

State	<input type="checkbox"/>	Profit	<input type="checkbox"/>	Individual	<input type="checkbox"/>
County	<input type="checkbox"/>	Nonprofit	<input type="checkbox"/>	Partnership	<input type="checkbox"/>
City	<input type="checkbox"/>			Corporation	<input type="checkbox"/>
Private	<input type="checkbox"/>				

V. OWNERSHIP Name and address of direct owner

NOTE: Provide the following supporting documentation as an attachment to this application:

- The name, mailing address, email address and phone number of each person having at least a twenty-five (25) percent ownership interest in the facility;
- If owned by a corporation, the name, mailing address, email address and phone number of each officer or director of the corporation;
- If owned by a partnership, the name, mailing address, email address and phone number of each partner.

VI. FIRE MARSHAL (FOR INITIAL, ADDITIONAL LOCATIONS/SATELLITES, AND CHANGE OF LOCATION APPLICATIONS. NOT APPLICABLE FOR HEALTH MAINTENANCE ORGANIZATIONS AND NETWORKS.)

Please submit documentation of the Fire Marshal's approval for the location(s) where services will be provided. Final approval from the Fire Marshal shall be considered current if approved within 12 months from the date the Office of Inspector General receives the licensure application. If your facility has not been inspected and approved within the previous 12 months, please contact the Fire Marshal's Office to request an inspection.

An incomplete application or failure to submit the applicable licensure fee may result in return of the application to the applicant. A completed application should not be submitted to the Office of Inspector General until the facility is ready for an inspection.

I understand that **any change** in the information provided in within this application affecting the licensure status of this facility or service will be reported to the Office of Inspector General and **a new application** will be completed at that time. I agree that this facility/service and all aspects of its operation shall allow all state agency licensure personnel entrance upon its premises for the purpose of inspection. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application may result in denial or revocation of licensure.

Signature of Authorized Representative

Title

Date

Submit the application, fee and supportive documentation to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621