Print Form

UTAH DEPARTMENT OF HEALTH
DIVISION OF FAMILY HEALTH AND PREPAREDNESS
BUREAU OF HEALTH FACILITY LICENSING AND CERTIFICATION

PO BOX 144103
SALT LAKE CITY, UT 84114-4103
(801) 273-2994
(800) 662-4157 toll free
(801) 274-0658 Fax

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REQUEST FOR AGENCY ACTION/LICENSE APPLICATION

A. IDENTIFYING INFORMATION

FACILITY/AGENCY NAME

STREET ADDRESS	MAILING ADDRESS (if different than street address)
STREET ADDRESS CONTINUED	MAILING ADDRESS CONTINUED

CITY | STATE | ZIP | CITY | STATE | ZIP

PHONE NUMBER | FAX NUMBER

FACILITY EMAIL

ADMINISTRATOR | PHONE NUMBER

PROFESSIONAL LICENSE? YES ☐ NO ☐ NUMBER | CATEGORY

ADMINISTRATOR EMAIL

EMERGENCY CONTACT NAME | PHONE NUMBER

B. ACTION REQUESTED

☐ INITIAL LICENSE	Include fees, DACS clearance, city business license and for inpatient facilities - fire clearance, certificate of occupancy, zoning, kitchen inspection
☐ LICENSE RENEWAL	Include fees, DACS clearance and for inpatient facilities - fire clearance
☐ CHANGE OF OWNERSHIP	Include agreement, fees, DACS clearance, city business license and for inpatient facilities - fire clearance, kitchen inspection
☐ CHANGE OF ADMINISTRATOR	Include name of new administrator, qualifications, fees, DACS submitted
☐ CHANGE IN LOCATION	Include fees, city business license and for inpatient facilities - fire clearance, certificate of occupancy, zoning, kitchen inspection
☐ CHANGE IN NAME	Include fees, city business license
☐ CHANGE IN CAPACITY	Include fees, fire clearance
☐ CHANGE IN MANAGEMENT	Include fees

DATE OF ACTION REQUESTED:

C. VARIANCE CONTINUATION / DEEMED STATUS

☐ VARIANCE CONTINUATION IDENTIFY RULE

☐ INITIATE DEEMED STATUS ☐ CONTINUE DEEMED STATUS ☐ RELINQUISH DEEMED STATUS

DATE OF ACCREDITATION | ACCREDITING AGENCY

D. TYPE OF FACILITY

◯ ACUTE HOSPITAL

NUMBER OF BEDS ACUTE [ ] SWING BEDS [ ] TYPE OF EMERGENCY SERVICES (LEVEL I - IV) [ ]

◯ SATELLITE TYPE [ ]

◯ SPECIALTY HOSPITAL

☐ PSYCHIATRIC ☐ CHEMICAL DEPENDENCY/SUBSTANCE ABUSE ☐ REHABILITATION

☐ LONG TERM ACUTE CARE ☐ ORTHOPEDIC ☐ CRITICAL ACCESS

NUMBER OF BEDS [ ] TYPE OF EMERGENCY SERVICES (LEVEL I-IV) [ ]

◯ SATELLITE TYPE [ ]

◯ NURSING CARE FACILITY NUMBER OF SKILLED BEDS [ ] NUMBER OF INTERMEDIATE BEDS [ ]

NUMBER OF LICENSED ONLY BEDS [ ] NUMBER OF DUALLY CERTIFIED BEDS [ ]

SECURE UNIT YES ☐ NO ☐ TOTAL NUMBER OF BEDS [ ]

◯ INTERMEDIATE CARE FACILITY FOR PEOPLE WITH AN INTELLECTUAL DISABILITY NUMBER OF BEDS [ ]

◯ SMALL HEALTH CARE FACILITY

NUMBER OF NURSING BEDS [ ] NUMBER OF TYPE "N" BEDS [ ] NUMBER OF ICF/ID BEDS [ ]

◯ ASSISTED LIVING FACILITY - TYPE I TOTAL NUMBER OF BEDS [ ]

◯ ASSISTED LIVING FACILITY - TYPE II TOTAL NUMBER OF BEDS [ ]

SECURE UNIT YES ☐ NO ☐ NUMBER OF SECURE UNIT BEDS [ ]

◯ AMBULATORY SURGICAL CENTER NUMBER OF SURGERY ROOMS [ ]

◯ BIRTHING CENTER NUMBER OF BIRTHING ROOMS [ ]

◯ ABORTION CLINIC - TYPE I NUMBER OF TREATMENT ROOMS [ ]

◯ ABORTION CLINIC - TYPE II NUMBER OF TREATMENT ROOMS [ ]

◯ END STAGE RENAL DISEASE CENTER NUMBER OF DIALYSIS STATIONS [ ]

◯ HOME HEALTH AGENCY ◯ Parent ◯ Branch

◯ PERSONAL CARE AGENCY ◯ Parent ◯ Branch

◯ HOSPICE ◯ Parent ◯ Branch ◯ In-Patient ◯ Out-Patient

E. OWNERSHIP OF FACILITY/AGENCY

Indicate the type of ownership, including the name and address for each.

◯ Individual (Also include documentation to verify citizenship) ◯ Corporation ◯ Partnership ◯ Limited Liability Corporation

◯ Other (Describe)

OWNERSHIP NAME							
OWNERSHIP EMAIL				PHONE NUMBER			
STREET ADDRESS		CITY		STATE		ZIP	

F. OFFICERS/OWNERS OF FACILITY/AGENCY

Indicate the percentage of ownership interest of the officer, member of the board of directors, trustees, stockholders, partners or other persons who have interest in the facility. Add additional pages if necessary.

OWNER NAME		TITLE		PERCENT OF OWNERSHIP			
STREET ADDRESS		CITY		STATE		ZIP	
OWNER NAME		TITLE		PERCENT OF OWNERSHIP			
STREET ADDRESS		CITY		STATE		ZIP	
OWNER NAME		TITLE		PERCENT OF OWNERSHIP			
STREET ADDRESS		CITY		STATE		ZIP	
OWNER NAME		TITLE		PERCENT OF OWNERSHIP			
STREET ADDRESS		CITY		STATE		ZIP	

G. OPERATION/MANAGEMENT OF FACILITY/AGENCY

Indicate the type of ownership, for the operation/management of the facility/agency including the name and address for each.

◯ Individual ◯ Corporation ◯ Partnership ◯ Limited Liability Corporation ◯ Other (Describe)

OWNERSHIP NAME				PHONE NUMBER			
STREET ADDRESS		CITY		STATE		ZIP	

I. EACH OF THE INDIVIDUALS LISTED IN THE ABOVE OWNERSHIP/MANAGEMENT SECTIONS HAVE ATTESTED TO THE LICENSEE THAT THEY:

a) Have never been convicted of a felony

b) Have never been found in violation of any local, state, or federal law which arises from or is otherwise related to the individuals relationship to a health care facility; and

c) Have not currently or within the five years prior to the date of the application had previous interest in a licensed health care facility that had been any of the following;

(i) Subject of a patient care receivership action

(ii) Closed as a result of a settlement agreement resulting from a decertification action of license revocation

(iii) Involuntarily terminated from participation in either Medicaid or Medicare programs

(iv) Convicted of patient abuse, neglect or exploitation where the facts of the case prove that the licensee failed to provide adequate protection or services for the person to prevent such abuse.

J. CERTIFICATE OF UNDERSTANDING

I _____ , as _____

(Name) (Title)

of the above named facility, understand this request constitutes a Request for Agency Action as specified in Utah Code Ann. 63G-4-101 et. seq. and serves as the formal document upon which a licensing decision will be based. I agree to abide by the rules promulgated by the State of Utah for this category of health care facility and do hereby state that the information provided on this application is true to the best of my knowledge and belief.

I further understand that I am responsible for admitting and retaining only those persons who qualify as defined in the applicable rules and facility policies and procedures. I agree to allow authorized representatives of the Department of Health, upon presentation of proper identification, to enter the facility at any reasonable time without warrant and to review facility records and documents as necessary to ascertain compliance with State licensing laws and rules promulgated by the Health Facility Committee.

SIGNATURE _____ DATE _____