



REQUEST FOR AGENCY ACTION/LICENSE APPLICATION

A. IDENTIFYING INFORMATION

Form section A containing fields for Facility/Agency Name, Street Address, Mailing Address, City, State, ZIP, Phone Number, Fax Number, Facility Email, Administrator, Professional License, Administrator Email, and Emergency Contact Name.

B. ACTION REQUESTED

Form section B containing checkboxes for Initial License, License Renewal, Change of Ownership, Change of Administrator, Change in Location, Change in Name, Change in Capacity, and Change in Management, along with a Date of Action Requested field.

C. VARIANCE CONTINUATION / DEEMED STATUS

Form section C containing checkboxes for Variance Continuation, Initiate Deemed Status, Continue Deemed Status, and Relinquish Deemed Status, along with fields for Date of Accreditation and 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

SECURE UNIT YES  NO  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 NUMBER OF BEDS

ASSISTED LIVING FACILITY - TYPE II NUMBER OF BEDS

SECURE UNIT YES  NO  NUMBER OF 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	<input type="text"/>	PHONE NUMBER	<input type="text"/>
STREET ADDRESS	<input type="text"/>	CITY	<input type="text"/>
		STATE	<input type="text"/>
		ZIP	<input type="text"/>

**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 greater than 25% interest in the facility. Add additional pages if necessary.

OWNER NAME	<input type="text"/>	TITLE	<input type="text"/>	PERCENT OF OWNERSHIP	<input type="text"/>
STREET ADDRESS	<input type="text"/>	CITY	<input type="text"/>	STATE	<input type="text"/>
				ZIP	<input type="text"/>
OWNER NAME	<input type="text"/>	TITLE	<input type="text"/>	PERCENT OF OWNERSHIP	<input type="text"/>
STREET ADDRESS	<input type="text"/>	CITY	<input type="text"/>	STATE	<input type="text"/>
				ZIP	<input type="text"/>
OWNER NAME	<input type="text"/>	TITLE	<input type="text"/>	PERCENT OF OWNERSHIP	<input type="text"/>
STREET ADDRESS	<input type="text"/>	CITY	<input type="text"/>	STATE	<input type="text"/>
				ZIP	<input type="text"/>

**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	<input type="text"/>	PHONE NUMBER	<input type="text"/>
STREET ADDRESS	<input type="text"/>	CITY	<input type="text"/>
		STATE	<input type="text"/>
		ZIP	<input type="text"/>

**H. OFFICERS/OWNERS OF THE OPERATION/MANAGEMENT OF THE 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 greater than 25% interest in the operation/management of the facility

OWNER NAME	<input type="text"/>	TITLE	<input type="text"/>	PERCENT OF OWNERSHIP	<input type="text"/>
STREET ADDRESS	<input type="text"/>	CITY	<input type="text"/>	STATE	<input type="text"/>
				ZIP	<input type="text"/>
OWNER NAME	<input type="text"/>	TITLE	<input type="text"/>	PERCENT OF OWNERSHIP	<input type="text"/>
STREET ADDRESS	<input type="text"/>	CITY	<input type="text"/>	STATE	<input type="text"/>
				ZIP	<input type="text"/>
OWNER NAME	<input type="text"/>	TITLE	<input type="text"/>	PERCENT OF OWNERSHIP	<input type="text"/>
STREET ADDRESS	<input type="text"/>	CITY	<input type="text"/>	STATE	<input type="text"/>
				ZIP	<input type="text"/>

**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