



State of Alaska  
Department of Health & Social Services  
**Freestanding Birth Center**  
Licensure Application



## GENERAL APPLICATION INSTRUCTIONS

Pursuant to the [AS 47.32](#) Licensing Statute and the regulations of the Department of Health & Social Services Freestanding Birth Center Licensing requirements ([7 AAC 10](#) and [7 AAC 12.400](#)).

BEFORE ATTEMPTING TO COMPLETE THIS APPLICATION, PLEASE REVIEW THE BIRTH CENTER LICENSING RULES AND REGULATIONS. The rules and regulations can be downloaded from the Alaska Administrative Code, regulations for Birth Center licensure.

- ❖ Criminal Background Check [7 AAC 10.900 - 990](#)
- ❖ General Variance Procedures [7 AAC 10.9500 - 9535](#)
- ❖ Inspections and Investigations [7 AAC 10.9600 - 9620](#)
- ❖ Free Standing Birth Centers [7 AAC 12.400 - 446](#)
- ❖ General Provisions [7 AAC 12.600 - 990](#) (as applicable)

1. This application is valid for initial licensing, biannual renewals, and license modifications. Please use the provided area on the top of page 2 to clearly indicate the purpose of this application.
2. Application must be completed in full, to include the required attachments, for initial licensing and for biannual license renewals unless otherwise stated. License modification applications are only required to include the information regarding the changes being made.
3. This applicant should be completed electronically (i.e. Adobe). In the event the individual completing this application is unable to do so, a hand written application using blue or black ink and clearly legible may be accepted.
4. 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 spaces of this application and should be indicated with "see attached page #".
5. This application must be executed and verified by the individual owner or by two officers in the case of a birth center-owned corporation, association, or governmental unit or agency.
6. A separate application should be completed for birth centers operating in a separate location, unless the facilities are functioning under the same license.

### **Additional Instructions for Completing a License Application for a Freestanding Birth Center**

**7 AAC 12.405(d) Governing Body** - This section of the freestanding birth center licensing requirements states that the birth center's governing body must be formally organized in accordance with written by-laws.

1. A copy of the birth center's governing body by-laws must be submitted with initial license applications only. However, should the by-laws be amended at any time during the licensing period, copy should be included with the next biannual renewal application.

### **Definition**

7. Definition of freestanding birth center. For the purposes of this application, the term freestanding birth center means a facility that is not a part of a hospital and that provides a birth service to maternal clients; (AS 47.32.900(8)).



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THE DEPARTMENT IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER [AS 47.32.040](#).

This application can be used for initial licensure applications, license modifications and license renewals. Please check the appropriate box above to indicate the purpose of this application.

Select one:       Initial Application       Renewal Application       Modification Application

For modifications, what type of modification(s) (check all that apply):

- Change of Ownership                       Change of Physical Address
- Increase/decrease Bed Count -- Previous Bed Count:       New Bed Count:
- Other (please provide a brief description):

**I.      FACILITY NAME AND LOCATION**

Exact Legal Name:

Doing Business As:

Mailing Address:

City       State:       Zip Code:

Physical Address (If different from above):

City       State:       Zip Code:

Primary Phone Number for Public Use:

Primary Fax Number for Public Use:

Administration Phone Number for HFL&C Use:

Facility's Fiscal Period (month/day):  to

In an attempt to keep communications open and efficient, we will be maintaining generic email addresses that can be used to communicate with all of our facilities. If available, please provide a generic email address, such as *info@abcfacility.com*.

a.    Generic Email:



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**II. OWNERSHIP AND CONTROL**

A. Type of Control (check one)

GOVERNMENTAL

NON-PROFIT

PROPRIETARY

Other (Explain)

B. If Individual or Partnership owned (list all persons who own the Freestanding Birth Center)

Name

Address

<input type="text"/>	<input type="text"/>

C. Names under which persons in B. do business (other than this Freestanding Birth Center)

Name

Business

<input type="text"/>	<input type="text"/>

D. Corporate Ownership

(1) Name of Corporation

(2) State where Parent Firm or Organization is Incorporated or Registered



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(3) List title, name and address of each corporate officer

Title	Name	Address

E. List names and address of each shareholder holding more than 5 percent of shares OR ownership

Name	Address	Percent of Shares

F. For other than individual ownership, list the name and address of the Alaska registered agent or the person(s) legally authorized to receive service of process for the facility.

Name of Registered Agent	Address

G. List the names and addresses of all persons OR corporation under contract to manage or operate the facility

(Check here if not applicable)




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**H.** Have any of the following been convicted of a felony or of two or more misdemeanors involving moral turpitude in the last five years? **(If yes, attach explanation as Exhibit I.)**

- |    |  |                              |                             |
|----|--|------------------------------|-----------------------------|
| 1. | Applicant                                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. | Any member of a firm or partnership          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. | Any officer or director of a corporation     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. | Administrator or manager of the Birth Center | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**I.** Official name of governing body

(e.g. BOARD OF TRUSTEES, BOARD OF DIRECTORS, ETC.)

President

Address

Vice President

Address

Secretary

Address

**J.** If the facility or building is operated on a lease or rental basis, please specify ownership



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K. Trust or Endowment Operated - Complete for trustee

Trustee Name

Complete Address

City  State  ZIP Code

L. Additional Facility Operations - If the legal entity designated as the operator/licensee operates any other freestanding birth center, list the name and address of each facility. Letters from each state (other than Alaska) verifying licensure and compliance are required.

Facility Name

Complete Address

City  State  ZIP Code

Facility Name

Complete Address

City  State  ZIP Code

Facility Name

Complete Address

City  State  ZIP Code

**III. ADMINISTRATION**

A. Administrator

Name

Address

Telephone Number

License or Certification Number (if applicable)



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B. The operator/licensee will employ a management company?

Yes       No       N/A

Company Name

Complete Address

City

State

ZIP Code

Telephone Number

C. Future Expansion: Does your facility plan to add new or delete present services and/or facilities during the next period for which this license is issued?

Yes       No

If yes, please describe

D. Service Area: Please describe the proposed or actual service area. Include any environmental factors that might affect access to the birth center or transfer to a hospital.



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E. Availability of and access to maternal and newborn services:

1. **Staffing:** Please give the full time equivalents (FTE)

	Employed Staff	Contractual	Total FTE
Certified Nurse Midwives	<input type="text"/>	<input type="text"/>	<input type="text"/>
Direct Entry Midwives	<input type="text"/>	<input type="text"/>	<input type="text"/>
Registered Nurses	<input type="text"/>	<input type="text"/>	<input type="text"/>
Licensed Practical Nurses	<input type="text"/>	<input type="text"/>	<input type="text"/>
Nurse Practitioners	<input type="text"/>	<input type="text"/>	<input type="text"/>
Clinical Support Staff	<input type="text"/>	<input type="text"/>	<input type="text"/>
Others	<input type="text"/>	<input type="text"/>	<input type="text"/>

Is there an experienced physician or certified nurse midwife immediately available to the birth center by radio, telephone, or another means of direct communication for consultation or transfer of care?

Yes       No

If so, name of practitioner?

Current Alaska License Number

Is he/she  On Staff       Contract or Agreement

On Call

List the names of all midwives practicing at the birth center.

Name

<input type="text"/>	Current Alaska License Number	<input type="text"/>
<input type="text"/>	Current Alaska License Number	<input type="text"/>
<input type="text"/>	Current Alaska License Number	<input type="text"/>
<input type="text"/>	Current Alaska License Number	<input type="text"/>
<input type="text"/>	Current Alaska License Number	<input type="text"/>
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<input type="text"/>	Current Alaska License Number	<input type="text"/>
<input type="text"/>	Current Alaska License Number	<input type="text"/>



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2. Hospital obstetrics and newborn services:

Nearest Hospital		
Does the hospital provide Obstetrics and newborn services?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Distance from birth center to nearest hospital in miles?		
Time required for transfer to hospital in normal conditions?		

3. Does the birth center provide home birth services?  Yes  No

4. Does the birth center provide a family-centered maternity care program?  
 Yes  No

If not, is a family-centered maternity care program available in the service area?  
 Yes  No

5. Does the birth center provide clinics for disadvantaged families?  
 Yes  No

If not, are clinics available in the service area for disadvantaged families?

Yes  No



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6. Does the birth center provide laboratory services?  Yes  No

If "Yes" Please describe.

If "Yes" does the facility have a CLIA certificate?  Yes  No

7. Does the birth center provide supplementary social and welfare service?

Yes  No

If not, are social and welfare services available in the service area?

Yes  No

Please describe

8. Does the birth center provide childbirth education?  Yes  No

If not, is there a childbirth education program available in the service area?

Yes  No

Please describe

9. Does the birth center provide a parental support program?

Yes  No

If not, is there a parental support program available in the service area?

Yes  No

If not, is a family-centered maternity care program available in the service area?

Yes  No

10. How many Birthing Rooms does the birth center have?



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F. Describe the birth center's impact on the community and the needs of childbearing families in the population served.

G. Birth Centers requesting License Renewal Only

1. Has there been any changes in the population served since the previous application was submitted?

Yes       No

If yes, please describe.

2. How many births at the birth center during the previous 12 months?

3. How many births with complications that required transfer of the newborn to a hospital during the previous 12 months?

4. How many births with complications that required transfer of the client to a hospital during the previous 12 months?

H. New additions and remodeling

Is the birth center building a new addition or making remodeling changes at the present time?



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**IV. INSURANCE**

A. Does the facility have current Malpractice Insurance?  Yes  No

B. If yes please provide the following:

Company

Address

Expiration Date

**V. 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

**VI. ACCREDITATION**

**STATE LICENSING SURVEY WAIVER FOR ACCREDITED FACILITIES**

A. Will the facility be fully approved by an accrediting organization?  Yes  No

B. Has the facility requested appraisal by an accrediting body?  Yes  No

C. Accrediting body

- Date of last Accrediting Body Survey

- Type of survey

- Date accreditation expires

- Frequency of accreditation cycle

**VII. STATE LICENSING SURVEY WAIVER FOR ACCREDITED FACILITIES**

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 refer to [7 ACC 12.925](#) and [AS 47.32.030\(a\)\(9\)\(A-C\)](#).

❖ Would you like to apply for this waiver?  Yes\*  No

\* To apply, please include the following information with this application:

Copy of the most recent survey report AND any associated Plan of Correction

Completed State Licensing Survey Waiver Application (attached to the end of this application)



**State of Alaska**  
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**Payment Submission Form**  
 Licensure Fee Payments



**Licensure Fee Payment Submission Form**

Remit this form along with payment – see [7 AAC 12.615](#) for specific fees due

<b>Facility Type:</b>		<b>Date:</b>	
<b>Brief Payment Description:</b>			
<b>Facility Name:</b>			
<b>Facility Location:</b>			
<b>Facility Contact:</b>			
<b>Contact Number:</b>			
<b>License Number:</b>			
<b>Licensure Fee:</b>			
<b>Provisional Licensure Fee:</b>			
<b>Bed Fee (if applicable):</b>			
<i>Number of Beds/FTE's (if applicable):</i>			
<b>Revisit Fee:</b>			
<b>Modification Fee:</b>			
<b>Fine Amount:</b>			
<b>Total Amount of Payment Due:</b>			

**Make checks payable to: State of Alaska - HFLC**

**For State of Alaska accounting use only**

**Unit: 4011   Fund: 1004   Dept: 06   Appropriation: 062330704   Revenue: 5101**  
**Activity:    4HF0 License Fee    4HF1 Revisit Fee    4HF2 Modification Fee    4HF3 Fine**

Check #		Deposit number:	
Date received:		Deposit date:	
Received by:		IRIS document code:	
Info to TPL for processing:			
Return check date:			
Reason for return:			



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**State Licensure Attestation**  
 Attestation Form



**ATTESTATION**

The applicant, or the person authorized to submit this 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 gives 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.**       Yes       No

**If the facility is not yet in compliance or is not prepared for an on-site inspection, please give the expected date the facility will be in compliance.**

Date Full Compliance with Licensure is expected:

Printed Name of Administrator or Designee:

Signature of Administrator or Designee:       Date:

**Please submit this application and associated licensing fees to:**

Health Facilities Licensing & Certification  
 ATTN: Administrative Assistant  
 4501 Business Park Blvd. Suite 24 Bldg. L Anchorage, AK  
 99503

Phone: (907) 334-2483  
 Secure Fax: (907) 334-2682  
 Email: [dhcs.hflc@alaska.gov](mailto:dhcs.hflc@alaska.gov) (\*NOT secure)

**Note: To submit by E-mail, print, sign above and scan as a PDF file. The signed and completed application and associated documentation can be attached to an email and sent to [dhcs.hflc@alaska.gov](mailto:dhcs.hflc@alaska.gov).**