



State of Alaska
Department of Health & Social Services
Hospital
Licensure Application



Application for Hospital Licensure
GENERAL INSTRUCTIONS

- A. This application is for both initial and renewal of licensure.
- B. All items of information on the Application for Hospital Licensure form must be filled in when a hospital makes it's initial and/or renewal application for license.
- C. Prepare the application form in duplicate; send the original to the Health Facilities Licensing & Certification at the address on the last page of this application, or e-mail to the e-mail address on the last page.
- D. Please complete using PDF or print and complete. Print legibly with permanent type ink.
- E. The applicant should feel free to provide additional information on an attached sheet. This should be done whenever the space on the form is inadequate to give a complete answer.
- F. This application *must* be executed and verified by the individual owner or by an authorized officers in the case of a hospital-owned corporation, association, or governmental unit or agency.
- G. There is a license fee. See 7 AAC 12.615 for specific fees due.
- H. If the hospital's location, ownership changes, or a change in clinical services results in a change of license category, a re-application is also required.
- I. Separate applications are required for hospitals operated on separate premises, unless the facilities are functioning under one license,
- J. Separate applications are required for each individual hospital that is licensed separately, even though ownership is the same.
- K. Upon renewal, documents provided previously as part of a license application need not be provided again unless there have been changes, or as requested by the Department.

Additional instruction for completing the application for initial hospital license

[7 AAC 12.630\(b\)](#) Governing Body

This section of the hospital licensing requirements states that the hospital governing body must be formally organized in accordance with written by-laws.

If this is an initial application, please include a copy of the hospital's governing body by-laws as part of this application.

Definitions

1. Definition of Hospital. For the purposes of this application, the term hospital means any institution, place, building or agency, public or private, whether organized for profit or not, devoted primarily to the maintenance and operations of facilities for the diagnosis, treatment and/or care of two or more unrelated persons admitted for overnight stay or longer in order to obtain medical, including obstetric, psychiatric and nursing, care of illness, disease, injury, infirmity or deformity. The term hospital includes General Acute Care Hospitals, Rural Primary Care Hospitals, Critical Access Hospitals, Long Term Acute Care Hospitals and Specialized Hospitals.
2. Bed complement. Give the present number of beds actually set up for in-patient care, including children's cribs. (Exclude bassinets in maternity department nurseries, but count those in pediatric departments and in premature nurseries if not located in the maternity department. Exclude labor and recovery beds.)
3. Bed capacity. Based only on space designed as patient rooms, whether or not beds are installed; compute the "normal" bed count requested in the application to be licensed.
4. Emergency capacity. Number of beds that can reasonably be added to the bed complement in periods of unusually high occupancy. Include the number of beds that can reasonably be added to the bed capacity in the case of an area wide disaster.



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Pursuant to the [AS 47.32 Licensing Statute](#) and the regulations of the Department of Health & Social Services Hospital Licensing requirements ([7 AAC 10](#) and [7 AAC 12](#)) application is hereby made for a license to establish, conduct and/or maintain a hospital.

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

- a. Criminal Background Check [7 AAC 10.900 - 990](#)
- b. General Variance Procedures [7 AAC 10.9500 - 9535](#)
- c. Inspections and Investigations [7 AAC 10.9600 - 9620](#)
- d. Hospitals [7 AAC 12.100 - 190](#)
- e. Specialized Hospitals [7 AAC 12.200 - 225](#)
- f. General Provisions [7 AAC 12.600 - 990](#)

Note: Retain a copy of the application for future reference.

IF YOU DO NOT TYPE THE APPLICATION USING ADOBE AND CHOOSE TO COMPLETE THE APPLICATION IN WRITING, **BE SURE TO MAKE NOTE OF DROP-DOWN BOXES** TO PROPERLY COMPLETE THIS APPLICATION.

DUE DATE FOR RENEWAL: THE DUE DATE IS 90 DAYS PRIOR TO THE EXPIRATION OF YOUR CURRENT LICENSE (AS 47.32.060)	Department Use Only
	License Number _____

I. TYPE OF LICENSE APPLYING FOR

Medicaid #

Choose One License # Medicare #

Choose One License Expiration Date

II. NAME AND LOCATION OF HOSPITAL

Exact Legal Name:

Mailing Address:

City State Zip Code

Premises Located (If different from above):

City State Zip Code

Main Phone Number for Public Use:

Administration Phone Number for HFL&C Use:

Administration Fax Number for HFL&C Use:

E-Mail Address for HFL&C Use:

Facility's Fiscal Period (i.e. MONTH/DAY) to (MONTH/DAY)

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



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III. 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 Hospital)

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

C. Names under which persons in B. do business (other than this Hospital)

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

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 Hospital | <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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IV. ADMINISTRATION

A. Administrator

Name

Address

Telephone Number

License or Certification Number (if applicable)

B. Medical Director

Name

Address

Telephone Number License Number

C. Director of Nursing

Name

Address

Telephone Number License Number

D. Bed Capacity

Number of beds for patients (exclude beds in emergency departments, labor and recovery rooms etc.)

NUMBER OF BEDS

Total Bed Complement

Bed Capacity (number of beds applying for)

Emergency Capacity

Long Term Care (swing beds / included in total bed capacity)



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Bed complement (breakdown of total bed complement by clinical service)

	BEDS
Internal Medicine	<input type="text"/>
General Surgical	<input type="text"/>
Gynecological and Obstetrics	<input type="text"/>
Intensive Care	<input type="text"/>
Coronary Care	<input type="text"/>
Acute Mental Illness	<input type="text"/>
Neonatal Intensive Care Level II	<input type="text"/>
Neonatal Intensive Care Level III	<input type="text"/>
Pediatrics	<input type="text"/>
Long Term Acute Care	<input type="text"/>
Restorative/Rehabilitation	<input type="text"/>
Other (please explain	<input type="text"/>

TOTAL

Number of bassinets in maternity department nurseries

Are any patient beds located in rooms below ground level? Yes No If so, how many?

Number of patient care days (exclusive of newborn) rendered in the last calendar or fiscal year?



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V. MEDICAL STAFF

Is the medical staff organized with written by-laws, officers, regular meetings, and written minutes?

Yes No

Is the medical staff "closed" (i.e. restricted to active staff only) or open?

(i.e. both active and courtesy groups?)

To what staff group do dentists belong?

V. DEPARTMENTS AND SERVICES

A. Dietary Department

Name of person in charge

Title

Current Alaska License Number

Has the hospital arranged for the service of a consultant dietitian if no full-time or par-time dietician is employed?

Yes No

B. Radiological Department

Is radiological service provided in the hospital? Yes

No

if not, name hospital, clinic or other facility providing this service

Types of services provided

Diagnostic

Radiologic

Yes No

Regular

No. of Radiographis Units

MA rating of each radiographic unit

Portable

No. of Radiographis Units

MA rating of each radiographic unit

Dental

No. of Radiographis Units

MA rating of each radiographic unit

Other

No. of Radiographis Units

MA rating of each radiographic unit

Fluoroscopic

Yes No

Radioactive isotopes

Yes No

Interventional

Yes No

Does Hospital policy make x-ray film of chest as a routine admission procedure?

Yes No



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B. Radiological Department (continued)

Therapeutic

Deep Therapy Yes No KVP rating of unit

Intermediate Yes No KVP rating of unit

Superficial Yes No KVP rating of unit

Radium (radon) therapy Yes No

Radioactive isotopes Yes No

Name of Physician in charge of service

Is he/she Board Certified? Yes No Current Alaska License Number

Is he/she Full Time Part Time days/week days/month On Call

If the hospital is not served by a full-time radiologist, or regularly visited by a part-time radiologist, is the radiological service supervised by a member of the medical staff?
 Yes No

Name Current Alaska License Number

Does the hospital radiology department utilize tele-radiology with a radiologist outside the State of Alaska?
 Yes No

If so, what is the radiologist's name?

Current Alaska License Number

C. Clinical Laboratory Department

Is the laboratory service provided in the hospital? Yes No CLIA #

if not, name hospital, clinic or other facility providing this service

check the types of services provided

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Tissue Pathology | <input type="checkbox"/> Histocompatibility | <input type="checkbox"/> Photography | <input type="checkbox"/> Basal Metabolism |
| <input type="checkbox"/> Clinical Pathology | <input type="checkbox"/> Blood bank | <input type="checkbox"/> Autopsy | <input type="checkbox"/> Hematology |
| <input type="checkbox"/> Radiobioassay | <input type="checkbox"/> Diagnostic Immunology | <input type="checkbox"/> Microbiology | <input type="checkbox"/> Chemistry |
| <input type="checkbox"/> Immunohematology | <input type="checkbox"/> Clinical Cytogenetics | <input type="checkbox"/> Other (specify) | |



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C. Clinical Laboratory Department (continued)

Name of Physician in charge of service

Is he/she Board Certified? Yes No Current Alaska License Number

Is he/she Full Time Part Time days/week days/month On Call

If the hospital is not served by a full-time pathologist, or regularly visited by a part-time pathologist, is the clinical laboratory service supervised by a member of the medical staff?
 Yes No

Name

D. Anesthesiology Department

Does the hospital provide anesthesia service? Yes No

If so, name of physician in charge?

Is he/she Board Certified? Yes No Current Alaska License Number

Is he/she Full Time Part Time days/week days/month On Call

If the hospital does not have an organized anesthesia service, is the anesthesia department supervised by a member of the medical staff?
 Yes No

Who usually gives anesthesia? M.D. Nurse Anesthetist Other (specify)

Is the person who usually gives anesthesia a hospital employee? Yes No

E. Outpatient Department

If the hospital has an organized out-patient department(s), please list the organized clinics conducted (e.g. STD, cancer, pre-natal, orthopedics, etc).



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E. Outpatient Department (continued)

If the hospital has no organized out-patient department, please check the types of services provided for outpatients:

- Laboratory Examination Emergency Services X-Ray examinations
 Outpatient surgical service X-Ray or radium therapy Other (specify)

F. Medical Department

Is there an organized medical department? Yes No

If so, name of physician in charge?

Is he/she Board Certified? Yes No Current Alaska License Number

Is he/she Full Time Part Time days/week days/month On Call

G. Surgical Department

Is there an organized surgical department? Yes No

If so, name of physician in charge?

Is he/she Board Certified? Yes No Current Alaska License Number

Is he/she Full Time Part Time days/week days/month On Call

H. Restorative and Rehabilitation Department

Is there a restoration and rehabilitation department? Yes No

check the types of services provided

- Physical Therapy Vocational counseling Dietary
 Occupational Therapy Therapeutic recreation Psychological
 Speech Pathology Social services Other (specify)

If so, name of person in charge?

Professional specialty Current Alaska License Number

Is he/she Full Time Part Time days/week days/month On Call



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I. Pathology Department

Is there an organized pathology department? Yes No
 Is there a tissue committee of the medical staff? Yes No
 Are anatomical pathological services provided? Yes No

if not, name hospital, clinic or other facility providing this service

Name of physician in charge?

Is he/she Board Certified? Yes No Current Alaska License Number

Is he/she Full Time Part Time days/week days/month On Call

J. Intensive Care Department

Is there an organized intensive care department? Yes No

Name of person in charge?

Is he/she Board Certified? Yes No Current Alaska License Number

Is he/she Full Time Part Time days/week days/month On Call

K. Dental Department

Is there an organized dental department? Yes No

Name of person in charge?

Is he/she Board Certified? Yes No Current Alaska License Number

Is he/she Full Time Part Time days/week days/month On Call

L. Social Service Department

Is there an organized social service department? Yes No

Name of person in charge?

Current Alaska License Number

Is he/she Full Time Part Time days/week days/month On Call



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M. Medical Records Department

Is there an organized medical records department? Yes No

Name of person in charge?

Is he/she Full Time Part Time days/week days/month On Call

N. Perinatal Department

Is there an organized perinatal department? Yes No

Name of person in charge?

Is he/she Full Time Part Time days/week days/month On Call

O. Emergency Department

Is there an organized emergency department? Yes No

Name of person in charge?

Is he/she Full Time Part Time days/week days/month On Call

P. Respiratory Therapy Department

Is there an organized respiratory therapy department? Yes No

Name of person in charge?

Is he/she Full Time Part Time days/week days/month On Call

Q. Psychiatric Department

Is there an organized psychiatric department? Yes No

Name of person in charge?

Is he/she Full Time Part Time days/week days/month On Call

R. Substance Abuse Department

Is there an organized substance abuse department? Yes No

Name of person in charge?

Is he/she Full Time Part Time days/week days/month On Call



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S. Nuclear Medicine Department

Is there an organized nuclear medicine department? Yes No

Name of person in charge?

Is he/she Full Time Part Time days/week days/month On Call

T. Coronary Care Department

Is there an organized coronary care department? Yes No

Name of person in charge?

Is he/she Full Time Part Time days/week days/month On Call

U. Infection Control Department

Is there an organized infection control department? Yes No

Name of person in charge?

Is he/she Full Time Part Time days/week days/month On Call

V. Quality Improvement Department

Is there an organized quality improvement department? Yes No

Name of person in charge?

Is he/she Full Time Part Time days/week days/month On Call

W. Risk Management Department

Is there an organized risk management department? Yes No

Name of person in charge?

Is he/she Full Time Part Time days/week days/month On Call



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VI. PERSONNEL BY DEPARTMENT

Please indicate the anticipated total number of full time employees (FTE) employed at the hospital per department. indicate the total FTEs in the appropriate category (employed or contractual) for the Department. If this application is for an existing licensed hospital then identify the total FTE on the last day of the most recent pay period. Include only paid employees. If one employee serves in more than one position, include them in both departments by the estimated fraction of the FTE for each department..

DEPARTMENT		Employed Staff	Contractual	Total FTE
A.	Administration			
B.	Business Office and Records			
C.	Medical Records and Library			
D.	Anesthesiology	Anesthesiologist		
		Nurse Anesthetist		
E.	Nursing	R.N		
		L.P.N.		
		C.N.A. (Certified Nurse Aide)		
		Others		
F.	Nursing Education	Administrative		
		Instructors		
G.	X-Ray and Radiology	Radiologists		
		Technicians		
		Others		
H.	Clinical Laboratory	Pathologists		
		Technicians		
		Others		



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DEPARTMENT		Employed Staff	Contractual	Total FTE
I.	Dietary	Supervisory	<input type="text"/>	<input type="text"/>
		Cooks and Bakers	<input type="text"/>	<input type="text"/>
		Diet Aides	<input type="text"/>	<input type="text"/>
		Others	<input type="text"/>	<input type="text"/>
J.	Pharmacy	Pharmacists	<input type="text"/>	<input type="text"/>
		Technicians	<input type="text"/>	<input type="text"/>
		Others	<input type="text"/>	<input type="text"/>
K.	Social Services	Social Workers	<input type="text"/>	<input type="text"/>
		Social Worker Assistants	<input type="text"/>	<input type="text"/>
		Others	<input type="text"/>	<input type="text"/>
L.	Restorative and Rehabilitative PT		<input type="text"/>	<input type="text"/>
		OT	<input type="text"/>	<input type="text"/>
		PTA	<input type="text"/>	<input type="text"/>
		OTA	<input type="text"/>	<input type="text"/>
		SP	<input type="text"/>	<input type="text"/>
		Others	<input type="text"/>	<input type="text"/>
M.	Housekeeping	<input type="text"/>	<input type="text"/>	<input type="text"/>
N.	Plant Operations Maintenance and Repair	<input type="text"/>	<input type="text"/>	<input type="text"/>
O.	Laundry	<input type="text"/>	<input type="text"/>	<input type="text"/>
P.	Professional Services (Primary Care)	Physicians - Surgeons	<input type="text"/>	<input type="text"/>
		Residents	<input type="text"/>	<input type="text"/>
		Interns	<input type="text"/>	<input type="text"/>
Q.	Dental	Dentists	<input type="text"/>	<input type="text"/>
		Others	<input type="text"/>	<input type="text"/>



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VII. PHYSICAL PLANT

A. Number of beds on each floor or wing.

Floor (wing) Name	# of Beds	Floor (wing) Name	# of Beds	Floor (wing) Name	# of Beds
<input type="text"/>					
Floor (wing) Name	# of Beds	Floor (wing) Name	# of Beds	Floor (wing) Name	# of Beds
<input type="text"/>					
Floor (wing) Name	# of Beds	Floor (wing) Name	# of Beds	Floor (wing) Name	# of Beds
<input type="text"/>					
Floor (wing) Name	# of Beds	Floor (wing) Name	# of Beds	Floor (wing) Name	# of Beds
<input type="text"/>					
Floor (wing) Name	# of Beds	Floor (wing) Name	# of Beds	Floor (wing) Name	# of Beds
<input type="text"/>					
Floor (wing) Name	# of Beds	Floor (wing) Name	# of Beds	Floor (wing) Name	# of Beds
<input type="text"/>					
Floor (wing) Name	# of Beds	Floor (wing) Name	# of Beds	Floor (wing) Name	# of Beds
<input type="text"/>					

B. Name of person in charge of the physical plant

C. New additions and remodeling

1. Is the hospital building a new addition or making remodeling changes at the present time? Yes No

If so, please describe

2. How will this affect the bed complement?

3. Did the hospital require a CON? Yes No

4. Estimated Cost?



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VIII. ACCREDITATION

A. Is the facility fully approved by the Joint Commission or another approved accrediting body?

- Yes No Full Provisional

B. Has the facility requested appraisal by an accrediting body?

- Yes No

C. Accrediting body

D. Date of last Accrediting Body Survey

E. Type of survey

D. Date accreditation expires

IX. INSURANCE

A. Does the facility have current Malpractice Insurance?

- Yes No

B. If yes please provide the following:

Company

Address

Expiration Date

X. CRIMINAL BACKGROUND CHECKS

A. 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

XI. FLOOR PLAN

Please attach a separate listing of room numbers, number of beds in each room and their primary use. Additionally, include rooms that are licensed for beds which have been changed to something other than inpatient use and can be converted back to inpatient beds within 24 hours.

NOTE: The Administrator should be prepared to present Certification and Licensing surveyors with a current bed count during the entrance conference of a licensure survey.



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I. Licensure Fee Payment Submission Form

Remit this form along with payment – see 7 AAC 12.615 for specific fees due

Facility Type:		Date:
Branch Location (if applicable)		
Facility Name:		
Facility Location:		
Facility Contact:		
Contact Number:		
License Number:		
Licensure Fee:		
Provisional Licensure Fee:		
Bed Fee (if applicable):		
Note No. of beds: ()		
Revisit Fee:		
Modification Fee:		
Total:		

Make checks payable to: State of Alaska - HFLC

Unit: 4011 Fund: 1004 Dept: 06 Appropriation: 062330704 Revenue: 5101
Activity (select one): 4HF0 License Fee 4HF1 Revisit Fee 4HF2 Modification Fee

For State of Alaska accounting use only

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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XII. ATTESTATION

The applicant, or the person authorized to submit the 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 of [7 AAC 12.100 - 180](#) (Hospitals), [7 AAC 12.200 - 225](#) (Specialized Hospitals), 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

Administrator or Designee Name

Date

Signature of Administrator or Designee

Please submit this application to:

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

Phone: (907) 334-2483
 Fax: (907) 334-2682
 Email: dhcs.hflc@alaska.gov

[Note: To submit by E-mail, print the document, sign above, and scan to a PDF file. Attach the signed PDF document to an E-mail and send to the above E-mail address.]



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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 (*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.



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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

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

[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 Licensing Survey Waiver Application
[7 AAC 12.925](#)



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\(a\)\(9\)\(A-C\)](#). To apply, please provide the following information.

Facility type: _____ AK License Number: _____

Facility name: _____

Satellite locations: Yes No (***If yes, inspection reports for these sites are also required*)

Physical address: _____

Mailing address: _____

Primary phone: _____ Primary fax: _____

Email for facility distribution list: _____

Administrator: _____ Administrator phone: _____

Administrator email: _____

Secondary contact: _____ Title: _____

2nd Contact phone: _____ 2nd Contact email: _____

Name of accrediting organization: _____

Date of last inspection: _____ Frequency of accreditation cycle (years/months): _____

Were any deficiencies identified during the last inspection? Yes No

If yes, have the deficiencies been corrected? Yes No

For any surveys completed in the past 2-3 months, in which the facility has not received the report or plan of correction has not been submitted, when do you expect to receive the survey report or submit the facility's plan of correction? _____

Person completing this form: _____

Signature: _____ Date Completed: _____

*****A copy of your last inspection report and plan of correction MUST be submitted with this application or the waiver will be denied.**

Application can be submitted by fax to 907-334-2682 or by email to dhcs.hflc@alaska.gov

FOR DIVISION USE ONLY

Date Application Received: _____ Includes requested attachments? Yes No

Application Reviewed by: _____ Date reviewed: _____

Application is: Approved Denied Approving Signature: _____