



State of Alaska  
Department of Health & Social Services  
**Nursing Home**  
Licensure Application



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**Application for Nursing Home Licensure**  
**GENERAL INSTRUCTIONS**

- A. This application is for both initial and renewal licensure.
- B. All items of information on the Application for Nursing Home Licensure form must be filled in when a nursing home makes its initial 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 two officers in the case of a nursing home-owned corporation, association, or governmental unit or agency.
- G. There is a license fee. See 7 AAC 12.615 for specific fees due.
- H. In addition, if the nursing home's location, ownership changes, or a change in services results in a change of license category, a re-application is also required.
- I. Separate applications are required for nursing homes operated on separate premises, unless the facilities are functioning under one license,
- J. Separate applications are required for each individual nursing home that is licensed separately, even though ownership is the same.
- K. Upon renewal, documents or information 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 nursing home license**

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

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

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

**Definitions**

1. Definition of Nursing Home. For the purposes of this application, the term nursing home means a facility that is primarily engaged in providing skilled nursing care or rehabilitative services and related services for those who, because of their mental or physical condition, require care and services above the level of room and board; "nursing facility" does not include a facility that is primarily for the care and treatment of mental diseases; ([AS 47.32.900\(17\)](#))
2. Bed complement. Give the present number of beds actually set up for in-patient care, including children's cribs.
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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**DUE DATE: 90 DAYS PRIOR TO THE EXPIRATION OF YOUR CURRENT LICENSE (AS 47.32.060)**

<b>Department Use Only</b>
License Number _____

Pursuant to the [AS 47.32](#) Licensing Statute and the regulations of the Department of Health & Social Services Nursing Home Licensure requirements ([7 AAC 10](#) and [7 AAC 12](#))

BEFORE ATTEMPTING TO COMPLETE THE APPLICATION, PLEASE REVIEW THE NURSING HOME LICENSING RULES AND REGULATIONS. The rules and regulations can be downloaded from the Alaska Administrative Code, regulations for Nursing Facilities licensure using the links below.

- 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. Nursing Facilities [7 AAC 12.250 - 290](#)
- e. General Provisions [7 AAC 12.600 - 990](#)

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

IF YOU DO NOT COMPLETE 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.

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

**I. TYPE OF LICENSE APPLYING FOR**

Choose One

License #  Medicare #

License Expiration Date

**II. NAME AND LOCATION OF NURSING HOME**

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:

Fiscal Period (i.e. MONTH/DAY)  to (MONTH/DAY)



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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 Nursing Home)

Name

Address


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

Name

Business


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 Nursing Home | <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 long-term care facility, 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



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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

NUMBER OF BEDS

Total Bed Complement	<input type="text"/>
Bed Capacity (number of beds applying for)	<input type="text"/>
Emergency Capacity	<input type="text"/>

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

Number of patient care days rendered in the last calendar or fiscal year?

Number of patients discharged and who died in the same period?



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

Yes       No       N/A

Company Name

Complete Address

City  State  ZIP Code

Telephone Number

**V. PERSONNEL BY DEPARTMENT**

Please indicate the anticipated total number of full time employees (FTE) employed at the nursing home per department. Indicate the total FTEs in the appropriate category (employed or contractual) for the Department. If this application is for an existing licensed nursing home 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	<input type="text"/>	<input type="text"/>	<input type="text"/>
B.	Business Office and Records	<input type="text"/>	<input type="text"/>	<input type="text"/>
C.	Medical Records and Library	<input type="text"/>	<input type="text"/>	<input type="text"/>
D.	Nursing			
	R.N	<input type="text"/>	<input type="text"/>	<input type="text"/>
	L.P.N.	<input type="text"/>	<input type="text"/>	<input type="text"/>
	C.N.A. (Certified Nurse Aide)	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Others	<input type="text"/>	<input type="text"/>	<input type="text"/>
E.	Nursing Education			
	Administrative	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Instructors	<input type="text"/>	<input type="text"/>	<input type="text"/>
F.	Dietary			
	Supervisory	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Cooks and Bakers	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Diet Aides	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Others	<input type="text"/>	<input type="text"/>	<input type="text"/>



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DEPARTMENT			Employed Staff	Contractual	Total FTE
G.	Pharmacy	Pharmacists	<input type="text"/>	<input type="text"/>	<input type="text"/>
		Technicians	<input type="text"/>	<input type="text"/>	<input type="text"/>
		Others	<input type="text"/>	<input type="text"/>	<input type="text"/>
H.	Social Services	Social Workers	<input type="text"/>	<input type="text"/>	<input type="text"/>
		Social Worker Assistants	<input type="text"/>	<input type="text"/>	<input type="text"/>
		Others	<input type="text"/>	<input type="text"/>	<input type="text"/>
I.	Restorative and Rehabilitative PT		<input type="text"/>	<input type="text"/>	<input type="text"/>
		OT	<input type="text"/>	<input type="text"/>	<input type="text"/>
		PTA	<input type="text"/>	<input type="text"/>	<input type="text"/>
		OTA	<input type="text"/>	<input type="text"/>	<input type="text"/>
		SP	<input type="text"/>	<input type="text"/>	<input type="text"/>
		Others	<input type="text"/>	<input type="text"/>	<input type="text"/>
J.	Housekeeping		<input type="text"/>	<input type="text"/>	<input type="text"/>
K.	Plant Operations Maintenance and Repair		<input type="text"/>	<input type="text"/>	<input type="text"/>
L.	Laundry		<input type="text"/>	<input type="text"/>	<input type="text"/>
M.	Professional Services (Primary Care)	Physicians	<input type="text"/>	<input type="text"/>	<input type="text"/>
		ANPs	<input type="text"/>	<input type="text"/>	<input type="text"/>
		PACs	<input type="text"/>	<input type="text"/>	<input type="text"/>
N.	Dental	Dentists	<input type="text"/>	<input type="text"/>	<input type="text"/>
		Others	<input type="text"/>	<input type="text"/>	<input type="text"/>



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O. Other Departments\*

\* If the nursing home has other organized departments or other employees, please list and designate the department or the employee's job title.

DEPARTMENT (or Job Title)	Speciality	Employed Staff	Contractual	Total FTE

VI. PHYSICAL PLANT

A. Name of person in charge of the physical plant

B. Number of beds on each floor or wing.

Floor (wing) Name	# of Beds	Floor (wing) Name	# of Beds	Floor (wing) Name	# of Beds
<input style="width: 150px; height: 25px;" type="text"/>	<input style="width: 100px; height: 25px;" type="text"/>	<input style="width: 150px; height: 25px;" type="text"/>	<input style="width: 100px; height: 25px;" type="text"/>	<input style="width: 150px; height: 25px;" type="text"/>	<input style="width: 100px; height: 25px;" type="text"/>
Floor (wing) Name	# of Beds	Floor (wing) Name	# of Beds	Floor (wing) Name	# of Beds
<input style="width: 150px; height: 25px;" type="text"/>	<input style="width: 100px; height: 25px;" type="text"/>	<input style="width: 150px; height: 25px;" type="text"/>	<input style="width: 100px; height: 25px;" type="text"/>	<input style="width: 150px; height: 25px;" type="text"/>	<input style="width: 100px; height: 25px;" type="text"/>
Floor (wing) Name	# of Beds	Floor (wing) Name	# of Beds	Floor (wing) Name	# of Beds
<input style="width: 150px; height: 25px;" type="text"/>	<input style="width: 100px; height: 25px;" type="text"/>	<input style="width: 150px; height: 25px;" type="text"/>	<input style="width: 100px; height: 25px;" type="text"/>	<input style="width: 150px; height: 25px;" type="text"/>	<input style="width: 100px; height: 25px;" type="text"/>



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C. New additions and remodeling

1. Is the nursing home building a new addition or making remodeling changes at the present time?

If so, please describe

2. How will this affect the bed complement?

3. Did the nursing home require a CON?

4. Estimated Cost?

**VII. INSURANCE**

A. Does the facility have current Malpractice Insurance?

Yes                       No

B. If yes please provide the following:

Company

Address

Expiration Date

**VIII. 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

**IX. 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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**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).**



**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:			



# State of Alaska

Department of Health & Social Services

## 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: \_\_\_\_\_ 2<sup>nd</sup> 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](mailto: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: \_\_\_\_\_