



State of Alaska
Department of Health & Social Services
Rural Health Clinic/Frontier Extended Stay Clinic
Licensure Application



Application for Rural Health Clinic/Frontier Extended Stay Clinic Licensure
GENERAL INSTRUCTIONS

- A. This application is for both initial and renewal licensure.
- B. All items of information on the Application for Rural Health Clinic (RHC)/Frontier Extended Stay Clinic (FESC) Licensure form must be filled in when a RHC/FESC 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 RHC/FESC-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 RHC/FESC'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 RHC/FESCs operated on separate premises, unless the facilities are functioning under one license,
- J. Separate applications are required for each individual RHC/FESC 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 RHC/FESC license

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

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

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

Definitions

- 1. Definition of Rural Health Clinic/Frontier Extended Stay Clinic. For the purposes of this application, the term "Frontier Extended Stay Clinic" means a rural health clinic that is authorized to provide 24-hour care to one or more individuals; ([AS 47.32.900\(9\)](#))
- 2. A "rural health clinic" means
 - A. a facility or clinic that is authorized to provide health care services and is located in a rural area;
 - B. includes a Frontier Extended Stay Clinic;
 - C. does not include a rehabilitation agency or a facility primarily for the care and treatment of mental diseases.
- 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)

Department Use Only

License Number _____

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

BEFORE ATTEMPTING TO COMPLETE THE APPLICATION, PLEASE REVIEW THE RHC/FESC LICENSING RULES AND REGULATIONS. The rules and regulations can be downloaded from links below for the Alaska Administrative Code, regulations for RHC/FESC 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. Frontier Extended Stay Clinics [7 AAC 12.450 - 490](#)
- e. General Provisions [7 AAC 12.600 - 990](#) (Applicable requirements)

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.

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 License # Medicare #

Choose One License Expiration Date

II. NAME AND LOCATION OF Rural Health Clinic (RHC)/Frontier Extended Stay Clinic (FESC)

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 RHC/FESC)

Name

Address

Name	Address

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

Name

Business

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	Yes	No
2.	Any member of a firm or partnership	Yes	No
3.	Any officer or director of a corporation	Yes	No
4.	Administrator or manager of the RHC/FESC	Yes	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

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: Does the facility have designated space and beds for treatment of RHC/FESC patients? Yes No

NOTE: (A RHC/FESC may not have more than 4 beds)

NUMBER OF BEDS

Bed Capacity (number of RHC/FESC beds applying for)

Emergency Capacity

Are any patient beds located in rooms below ground level?

Yes

No

If so, how many?



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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

F. The clinic currently operates as a (check all that apply):

V. GEOGRAPHICAL SERVICE AREA (Please describe the geographical service area of the clinic)

VI. INITIAL APPLICATIONS ONLY

- A. Please provide a copy of the facility's plan for the delivery of health services within the service area.
- B. Please provide a copy of the facility's plan for staffing when a patient is admitted for care or services in the RHC/FESC.
- C. Please provide a copy of the facility's emergency services plan that coordinates the provisions of emergency medical services in the service area.
- D. Please provide a description of the clinic's volume capacity.



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VII. PHYSICIAN RESPONSIBILITIES

- A. If this is an initial application, please provide a copy of the facility's plan that demonstrates how each physician's responsibilities will be accomplished, including record reviews, policy reviews, review of services provided, supervision, and medical direction,
OR
 if the facility's plan submitted in the initial or subsequent applications has been updated to reflect any changes since the last plan was submitted, please provide a copy of the updated plan.

VIII. RHC/FESC PATIENTS (License Renewal Only)

If this application is for renewal of the clinic's RHC/FESC license, please provide the number of patients admitted during the previous 12 months for extended stay including:

- A. The number of patients admitted for an extended stay described in 7 AAC 12.450(a)(2)(A);
[(A) are seriously ill, critically ill, or seriously injured and who cannot be transferred to a general acute care hospital, rural primary care hospital, or critical access hospital because of adverse weather conditions, unavailability of a transport vehicle, or another similar unavoidable circumstance;]

Number of Patients

- B. The number of patients admitted for an extended stay described in 7 AAC 12.450(a)(2)(B);
[(B) are seriously ill, critically ill, or seriously injured and require transfer to a general acute care hospital, rural primary care hospital, or critical access hospital but exercise the right, against the medical advice of the attending practitioner, not to be transferred, and elect to receive extended stay services appropriate to manage the individual's illness or injuries to the extent possible within the clinic's capability;]

Number of Patients

- C. The number of patients admitted for monitoring and observation described in 7 AAC 12.450(a)(2)(C);
[(C) are not in obvious need of medical transport, but require an extended stay for monitoring and observation.]

Number of Patients

NOTE: Federal rules require that patients who receive extended stay for monitoring and observation may not exceed 48 hours.

- D. Please provide the average length of stay for each category set out in (A), (B) and (C).

Average for (A)

Average for (B)

Average for (C)

- E. Does the facility agree to limit the inpatient length of stay for monitoring and observation to 48 hours following Rural Health Clinic/Frontier Extended Stay Clinic certification?

Yes

No



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IX. COMPLIANCE

A. Does the facility meet, or intend to meet the requirements for licensure and Medicare certification as a Rural Health Clinic/Frontier Extended Stay Clinic?

Yes

No

B. If the facility does not now meet licensure requirements as a Rural Health Clinic/Frontier Extended Stay Clinic, please indicate the date the facility will be in compliance.

Date facility will be in compliance

Please Explain:

X. INSURANCE

A. Does the facility have current Malpractice Insurance?

Yes

No

B. If yes please provide the following:

Company

Address

Expiration Date



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XI. SERVICES

Please check services offered either directly or through contract or arrangement:

- | | | |
|---|-----------------------|----------------------|
| Emergency Care* | Nursing | Outpatient |
| Medical* | Dietary/food service | Respiratory Therapy |
| Psychiatric Therapy | Physical Therapy | Occupational Therapy |
| Medical Records | Radiology* | Pharmacy |
| Laboratory* | Social Services | Laundry |
| Extended stay for patients requiring medical transport* | | |
| Extended stay for patients requiring monitoring and observation | | |
| Other (Explain) | (* Required services) | |

XII. STAFFING

Please list full time equivalents

DEPARTMENT	Employed Staff	Contractual	Total FTE
A. Administration			
B. Business Office and Records			
C. Medical Records			
D. Professional Services (Primary Care)	Physicians		
	Physician Assistants		
	Advanced Nurse Practitioners		
	Others (specify)		



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DEPARTMENT		Employed Staff	Contractual	Total FTE
E.	Nursing	R.N		
		L.P.N.		
		C.N.A. (Certified Nurse Aide)		
		Others		
F.	X-Ray and Radiology	Radiologists		
		Technicians		
		Others		
G.	Clinical Laboratory	Pathologists		
		Technicians		
		Others		
H.	Pharmacy	Pharmacists		
		Technicians		
		Others		
I.	Social Services	Social Workers		
		Social Worker Assistants		
		Others		
J.	Housekeeping			
K.	Plant Operations Maintenance and Repair			
L.	Laundry			
M.	Dental	Dentists		
		Others		



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N. Other Staffing*

* If the clinic has other employees not included above, please list and designate the employee's job title.

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

XIV. FLOOR PLAN

Please attach a separate floor plan showing each floor of the building and each room, including the location of FESC beds.

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.

XV. LOCATION

A. The facility is located in a rural area of no more than 15,000 residents based on calculations of the United States Bureau of Census.

Yes No

B. Please indicate in mileage to nearest hospital

	Air	Highway
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C. If by highway, please indicate type of road

	Primary	Secondary
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D. What is the travel time to the nearest hospital?

Air hrs.

Highway hrs.



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XVI. AGREEMENT

Does the facility agree to limit the inpatient length of stay for monitoring and observation to 48 hours following Frontier Extended Stay Certification?

Yes No

XVII. RURAL HEALTH ACCESS TO CARE (Initial application only)

If this is an application for initial licensure for conversion to a frontier extended stay clinic, please attach an explanation of how conversion will promote regionalization of rural health services, and improve access to hospital care and other health services in the community you serve.

XVIII. OUTPATIENT CLINICS

Does the RHC/FESC have any outpatient clinics, either freestanding or as part of the facility, that are considered a unit (department) of the clinic?

Yes No

XIX. TELEMEDICINE

Does the facility 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

XX. OUTREACH

Does the facility have out-reach services?

Yes No Please describe

XXI. ADDITIONAL COMMENTS (please provide any additional comments or information you feel will contribute to the Departments decision related to an initial or renewal of the license.



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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: _____