# State of Alaska

Department of Health & Social Services

# Ambulatory Surgical Center

Licensure Application

**Pursuant to the AS 47.32 Licensing Statute and the regulations of the Department of Health & Social Services Ambulatory Surgical Center (ASC) Licensing requirements (7 AAC 10 and 7 AAC 12.350).**

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*):

_____

1. Application should be complete, clear and legible. After this application is completed it should be printed, signed in permanent ink and submitted to the State of Alaska, Health Facilities Licensing & Certification team. Contact info is located below.
2. 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 space and should indicate "see attached page #" or something similar.
3. This application must be executed and verified by the individual owner or by two officers in the case of a corporation, association or governmental unit or agency.
4. There are licensure fees associated with this application. Please see 7 AAC 12.615 for more information regarding the fees due for your facility. If there are any questions about these fees, please contact 907-334-2483.
5. A separate application is required for facility branches operated on separate premises if that facility operates under a separate license number. Separate applications are required for each individual facility that is licensed separately, even though ownership is the same.

## I. FACILITY NAME AND LOCATION

Exact Legal Name: _____

Doing Business As: _____

Physical Address: _____

City: _____ State: _____ Zip Code: _____

License Number: _____ Tax ID: _____

Mailing Address (*if different than above*): _____

Phone Number for Public Use: _____ Fax Number for Public Use: _____

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: _____

## II. OWNERSHIP AND ADMINISTRATION

**a. Type of Control (select one)**

GOVERNMENTAL: ☐ State ☐ Borough ☐ City

NOT FOR PROFIT: ☐ Church Operated or Affiliated

PROPRIETARY: ☐ Individual ☐ Partnership ☐ Corporation

OTHER: _____

**b. If Individual or Partnership Owned (list all owners)**

| Name | Address |
|---|---|
| | |
| | |
| | |
| | |
| | |

**c. Name of any other facilities any persons listed in (b) do business with (other than this facility)**

| Name | Business |
|---|---|
| | |
| | |
| | |
| | |

**d. Corporate Ownership**

- Name of Corporation: _____
- State where Parent Firm or Organization is Incorporated or Registered: _____
- List title, name, and address of each corporate officer

| Title | Name | Address |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**e. List name and address of each shareholder holding more than 5% 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 under contract to manage or operate the facility.**
☐ Check here if not applicable

| Name | Address |
|---|---|
| | |
| | |
| | |
| | |

**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)**

i. Applicant ☐ Yes ☐ No
ii. Any member of a firm of partnership ☐ Yes ☐ No
iii. Any officer or director of a corporation ☐ Yes ☐ No
iv. Administrator or manager of the ASC ☐ Yes ☐ No

## III. ADMINISTRATION AND PERSONNEL

**a. Administrator** (for initial applications please attach resume as Exhibit II)

Name: _____

Address: _____

Telephone Number: _____ License or Certification Number (if applicable): _____

**b. Medical Director** (for initial applications please attach resume as Exhibit III)

Name: _____

Address: _____

Telephone Number: _____ License or Certification Number: _____

**c. Supervising Nurse** (for initial applications please attach resume as Exhibit IV)

Name: _____

Address: _____

Telephone Number: _____ License or Certification Number: _____

**d. Medical Staff**: Provide a list of specialties, names, and license numbers of each physician, podiatrist, anesthesiologist, or dentist granted privileges to perform procedures in the center (attach as Exhibit V).

**e. Personnel:** Provide a list of positions and/or classification; name, education, experience, and professional licensure or certification (attach as Exhibit VI).

**f. Number of Operating Rooms**: _____

**g. List the types of procedures performed in the center** (attach additional pages as necessary)

| Procedures: | Procedures: | Procedures: |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## IV. ACCREDITATION

Will the facility be fully approved by an accreditation organization? ☐ Yes* ☐ No

* Yes, please provide the following information:

**a.** Accrediting body: _____

**b.** Date of last Accrediting Body Survey: _____

**c.** Type of Survey: _____

**d.** Date Accreditation Expires: _____

**e.** Frequency of Accreditation Cycle: _____

## V. STATE LICENSING SURVEY WAIVER FOR ACCEDITED 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).

**a.** 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)

## VI. INSURANCE

**a.** Does the facility have current Malpractice Insurance? ☐ Yes* ☐ No
*Yes, complete the information below

Company: _____

Address: _____

Expiration Date: _____

## VII. FUTURE EXPANSION

**a.** 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 attach a brief description on a separate page:

**b.** Certificate of Need Application Submitted? ☐ Yes* ☐ No
**If a Certificate of Need Application has been submitted, attach a copy of the Application and CON Planning Section decision as Exhibit VI.*

## VIII. CRIMINAL BACKGROUND CHECKS

**a.** Does this 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? ☐ Yes ☐ No

## IX. FACILITIES, SERVICES, AND PROCEDURES

**The following must be included with the application:**

- ☐ A narrative of the facility including but not limited to interviewing, examination, surgical and recovery room facilities (Exhibit VII).
- ☐ Documentation of compliance with CLIA, Laboratory Services (Exhibit VIII).
- ☐ A copy of the transfer agreement with a licensed hospital within the same community as the facility or other documentation demonstrating compliance, such as all physicians performing procedures have admitting privileges at the nearest hospital (Exhibit IX).
- ☐ A copy if the organizational plan of the facility (Exhibit X).
- ☐ Floor plan (Exhibit XII).
- ☐ Documentation of compliance with all applicable local building, utility and safety codes (Exhibit XIII).

# State of Alaska

Department of Health & Social Services

# 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.**

# State of Alaska

Department of Health & Social Services

# 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:** | Select One | **Date:** | |
| | | | |
| **Brief Payment Description:** | | | |
| **Facility Name:** | | | |
| **Facility Location:** | | | |
| **Facility Contact:** | | | |
| **Contact Number:** | | | |
| **License Number:** | | | |
| | | | |
| **Licensure Fee:** | | | |
| **Provisional Licensure Fee:** | | | |
| **Bed Fee (if applicable):** | | | |
| *Number of Beds/FTE's (if applicable)*: | | | |
| **Revisit Fee:** | | | |
| **Modification Fee:** | | | |
| **Fine Amount:** | | | |
| **Total Amount of Payment Due:** | | | $ 0.00 |

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

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## 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: Select One _____ 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: _____