Instructions for Completion of the
Medical Care Facility Licensure Application
Please read the instructions carefully.

I. IDENTIFICATION:

A. Check classification as defined under KSA 65-425. A critical access hospital must also meet
the requirements of KSA 65-468 et seq.

B. Provide the full legal name and physical address of the facility including the nine-digit zip code.
   Provide the facility’s telephone number, fax number and e-mail address.

C. Identify the person designated by the governing authority to be responsible for the daily
   management of the facility. This person is usually referred to as the administrator/chief executive
   officer.

II. CONTROL AND GOVERNING AUTHORITY:

A. Read the information 1 thru 5 to complete Part II. Identify the disclosing entity type, as it is
   registered with the Kansas Secretary of State’s Office; or if the disclosing entity is government or
   county owned please indicate. List or attach the governing information, list the names, titles
   percentage of ownership and addresses.

B. Give the legal names of the organization that owns and or controls this medical care facility.

III. GENERAL INFORMATION:

A. FOR HOSPITALS ONLY: “General beds”, includes medical-surgical, rehabilitation,
   psychiatric, etc.

B. The active medical staff or the physician and dentist members who provide the preponderance of
   medical practice in the facility and perform all significant medical staff organizational and
   administrative functions.

C. Kansas law currently recognizes only JC, DNV and AOA accreditation for hospitals and AAAHC
   JC and AAAASF for ambulatory surgical centers state licensure purposes. Submit copy of the full
   survey with the AO Decision Letter which shows the effective dates of accreditation.

D. COMPLETE THIS ITEM ONLY IF ANSWERING “YES” TO ITEM III. If a survey has
   been conducted during a 12-month period prior to the date of application but the survey results
   and copy of the survey report have not been received, mark “NO”. If the survey was conducted
   more than 12 months before the application date but the results and survey report were received
   during the 12-month period, mark ‘yes’ and submit the report.

E. The term “organized” relative to a clinical department or service is one that is an
   organizational unit or a functional division of the facility or medical staff.

F. Clinical Laboratory Improvement Act (CLIA) certification.

* The red notations are new questions that may require submission of documentation.
Kansas Department of Health and Environment
Bureau of Community Health Systems & Health Facilities Program
Medical Care Facility Licensure Application
Initial; Annual Renewal; Change of Ownership or Amended Application

Health Facilities Program

Medical Care Facility Identification:

A. Classification of License select one:
   ☐ General Hospital  ☐ Critical Access Hospital
   ☐ Special Hospital  ☐ Ambulatory Surgery Center

B. Name of Medical Care Facility: ____________________________________________
   Address: __________________________________ City: __________________________
   Zip Code: ____________ Public Phone: ________________ Fax: ________________
   Web Address: __________________________________________________________

* Ambulatory Surgery Centers List Days and Hours of Operations for this ASC:
   Days Open: ____________________________ Operation Hours: ______________________

Administration Information:

C. Chief Executive Officer: ____________________________________________
   Desk phone ________________ Email address ____________________________

* Chief of Medical Staff: ____________________________________________
   Email address: ________________ Phone: ____________________________

* Director or Risk Manager Name: __________________________________________
   Email address: ________________ Phone: ____________________________

__________________________________________
Do Not Write Below This Line, State Agency Use Only

Effective Date ________________ Facility I.D. Number ________________
Renewal Date ________________ Reviewed By ________________________
**Ownership Information:**

Select the Disclosing Entity type as it is registered with the Kansas Secretary of State’s Office and submit the Certificate of Good Standing from the Kansas Secretary of State’s Office.

1. List the name(s) and addresses of each person who has any direct or indirect ownership of **5 percent** or more in this entity.

2. List each person who is the owner (in whole or in part) of any mortgage, deed of trust, note or other obligation secured (in whole or in part) by such facility or any of the property or assets of such facility.

3. If the disclosing entity is organized as a corporation, attach a list showing the names and address of each Officer and or Director.

4. If the disclosing entity is organized as a limited partnership or limited liability company, please describe each limited liability for each 5 percent owner, and for all general partners.

5. If the disclosing entity is a governmental unit, attach a list showing the names and addresses of each responsible official (i.e., county commissioner).

**II. CONTROL AND GOVERNING AUTHORITY:**

A. Disclosing Entity’s Name: __________________________________________

   Physical Address: ____________________________________________________

   City/State Zip code

B. **Type of Entity:**

   - [ ] Corporation for profit
   - [ ] Corporation non-profit
   - [ ] Limited Liability Company (LLC)
   - [ ] Professional Associates (P.A.)
   - [ ] Government/County

   □ Other (Explain) ____________________________________________________

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General Information:

A. **(FOR HOSPITALS ONLY)** Number of Beds: General beds _____ Observation beds _____
   Swing beds _____ IPPS beds _____ LTC _____ Bassinets ______

B. Number of Active Medical Staff ______

C. **Check the box that applies:**
   - [ ] This applicant is licensed only
   - [ ] This applicant is licensed, accredited
   - [ ] This applicant is licensed, accredited and deemed to participate in Medicare by an approved accrediting organization.

D. Specify the Accrediting Organization ____________________________ and provide the current accrediting organization full survey with the decision letter.

   Provide the accreditation effective dates ____________________________

   *Submit copy of the (MCF) Certificate of Professional Liability Insurance i.e., the Declaration Letter.

E. The licensing regulations include standards for optional organized services, departments, or units.
   Check the boxes below that are provided by your facility. *Please submit the completed hospital database and or the ASC updated information worksheet.
   - [ ] Surgery department
   - [ ] Obstetrical department
   - [ ] Outpatient department
   - [ ] Pediatric department
   - [ ] Long Term Care Unit
   - [ ] Intensive coronary care units
   - [ ] Radiology
   - [ ] Social Services
   - [ ] Psychiatric Services
   - [ ] Dialysis Services
   - [ ] Physical Therapy
   - [ ] Occupational Therapy
   - [ ] Inhalation/respiratory Therapy

F. Does this facility hold a valid Clinical Laboratory Improvement Act (CLIA) certificate ________, please submit copy a of the current CLIA Certificate of Registration.

(Initials) __________ I the undersigned is authorized to represent the governing body, corporation, organization, individual, or partnership in whom is vested the responsibility for operation of the facility and certifies that the above information is true and correct.

I understand that this application may be subject to release pursuant to the Kansas Open Records Act (K.S.A. 45-215 et seq.).

________________________________________  __________________________________
Print Name                                      Title  Signature

________________________________________  __________________________________
Phone number                                    Date

The undersigned hereby applies to the Kansas Department of Health and Environment for a license to operate this medical care facility is subject to provisions under the Kansas Law.

Return completed application & documentation: Kansas Department of Health and Environment
Bureau of Community Health Systems
**Health Facilities Program**
1000 SW Jackson St., Suite 330
Topeka, Kansas 66612
Phone Number (785) 296-1258
email to lois.wilkins@ks.gov
Fax Number (785) 559-4250