

# 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.**





Select One:
<input type="checkbox"/> Initial
<input type="checkbox"/> Annual Renewal
<input type="checkbox"/> Change of Owner
<input type="checkbox"/> Amended _____

**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) \_\_\_\_\_

Table with 4 columns: Print Name, Title, Ownership %, Address. It contains five rows of empty header and data lines for recording owner information.

**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.

- |  |   |
|--|---|
| <input type="checkbox"/> Surgery department            | <input type="checkbox"/> Social Services                |
| <input type="checkbox"/> Obstetrical department        | <input type="checkbox"/> Psychiatric Services           |
| <input type="checkbox"/> Outpatient department         | <input type="checkbox"/> Dialysis Services              |
| <input type="checkbox"/> Pediatric department          | <input type="checkbox"/> Physical Therapy               |
| <input type="checkbox"/> Long Term Care Unit           | <input type="checkbox"/> Occupational Therapy           |
| <input type="checkbox"/> Intensive coronary care units | <input type="checkbox"/> Inhalation/respiratory Therapy |
| <input type="checkbox"/> Radiology                     |   |

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		
<b>Health Facilities Program</b>		
<b>1000 SW Jackson St., Suite 330</b>		
Topeka, Kansas 66612		
Phone Number (785) 296-1258	email to <a href="mailto:lois.wilkins@ks.gov">lois.wilkins@ks.gov</a>	Fax Number (785) 559-4250