

**INSTRUCTIONS FOR COMPLETING APPLICATION FOR
MEDICAL CARE FACILITY LICENSE**

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.
- C.** Provide the facility's telephone number, fax number and e-mail address.
- D.** 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.** Give the legal name of the organization that owns or controls this medical care facility.
- B.** Select the type of entity that describes the type of ownership and control of the facility. In the boxes below, read the information 1 thru 5 and complete the boxes or attach the information.

III. GENERAL INFORMATION

- A. FOR HOSPITALS ONLY:** Indicate all beds, including medical-surgical, rehabilitation, psychiatric, etc. following the word "general." All long-term care beds, including Medicare/Medicaid-certified skilled (SNF) or nursing facility (NF) beds following the words "long-term care."
- 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.** All categories of medical staff include: active, associate, courtesy, consulting and honorary members.
- D.** Kansas law currently recognizes only JCAHO and AOA accreditation for hospitals and AAAHC JACHO and AAAASF for ambulatory surgical centers state licensure purposes.
- E. 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.**
- F.** 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.
- G. Clinical Laboratory Improvement Act (CLIA) certification.**

<input type="checkbox"/> Initial
<input type="checkbox"/> Renewal
<input type="checkbox"/> Change Owner

**KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT
Bureau of Community Health Systems & Health Facilities Program
Initial Application, Annual Report or Change of Ownership(s)
LICENSE APPLICATION FOR MEDICAL CARE FACILITY**

DIVISION OF HEALTH

I. IDENTIFICATION:

A. Classification of License Requested: General Hospital ASC Critical Access Hospital Special Hospital

B. Name of Facility: _____ (Email) _____

C. Facility Address: _____ City _____ Zip _____

D. Chief Executive Officer: _____ Phone _____ Fax _____

II. CONTROL AND GOVERNING AUTHORITY

A. Disclosing Entity's Name: _____ Address _____

B. Type of Entity 1. Sole Proprietorship 2. Partnership 3. Joint Venture 4. Corporation for profit 5. Corporation not for profit

6. Government - Type _____ 7. Other (Explain) _____ 8. Limited Liability Company

COMPLETE THE BOXES BELOW WITH THE INFORMATION AS FOLLOWS FOR THE DISCLOSING ENTITY LISTED ON LINE A. ABOVE.

- List the name(s) and addresses of each person who has any direct or indirect ownership of **5 percent** or more in entity listed above.
- List each person who is the owner (in whole or in part) of any mortgage, deed or trust, note or other obligation secured (in whole or in part) by such facility or any of the property or assets of such facility.
- If the disclosing entity is organized as a corporation, attach a list showing the names and address of each officer and director.
- 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.
- If the disclosing entity is a governmental unit, attach a list showing the names and addresses of each responsible official (i.e, county commissioner).

INDICATE WITH "X"					INDIVIDUAL NAME	ADDRESS	CITY	STATE
1. OWNER	2. MORTGAGOR	3. DIRECTOR/OFFICERS	4. LIMITED LIABILITY Describe for each limited partnership & LLC the limited liability for each 5 % owner, and for all general partners.	5. ELECTED OFFICIALS	(or Attachment)			

Do Not Write Below This Line Agency Use Only

Effective Date _____

License ID No. _____

Renewal Date _____

Approved By _____

III. GENERAL INFORMATION:

A. (FOR HOSPITALS ONLY) Number of Beds: general _____ long-term-care _____ bassinets _____

List any other beds type and amount of beds licensed under this hospital license _____

B. Number of Active Medical Staff _____

C. Total Number of All Categories of Medical Staff _____

D. Check the ONE box that applies:

- The applicant is licensed only
- The applicant is licensed and accredited
- The applicant is licensed, accredited and deemed to participate in Medicare by an approved accrediting organization. Attach the **current survey and the decision letter to this application.**

E. Indicate Accrediting Organization _____ and the expiration date _____

F. The licensing regulations include standards for optional organized services, departments, or units. Check those below that are provided by your facility.

- | | |
|--|--|
| <input type="checkbox"/> surgery department | <input type="checkbox"/> social services department |
| <input type="checkbox"/> obstetrical department | <input type="checkbox"/> occupational therapy department |
| <input type="checkbox"/> pediatric department | <input type="checkbox"/> tuberculosis treatment |
| <input type="checkbox"/> outpatient department | <input type="checkbox"/> alcoholism treatment |
| <input type="checkbox"/> psychiatric department | <input type="checkbox"/> intensive/coronary care units |
| <input type="checkbox"/> physical therapy department | <input type="checkbox"/> long-term care units |
| <input type="checkbox"/> inhalation/respiratory therapy department | <input type="checkbox"/> radiology |
| <input type="checkbox"/> dialysis | |

G. Does this facility hold a valid Clinical Laboratory Improvement Act (CLIA) certificate or waiver?

- YES If yes, please attach copy a of the Certificate of Registration
- NO Contractor's CLIA number _____

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.

Signature Title

Print Name

Telephone 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.

<p>Return to: Kansas Department of Health and Environment Bureau of Community Health Systems Health Facilities Program 1000 SW Jackson St., Suite 330 Topeka, Kansas 66612</p> <p>Phone Number (785) 296-1258 Fax Number (785) 291-3419</p>
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