

LARA Use Only

Date Received
Facility Number

**STATE OF MICHIGAN  
HEALTH FACILITY/AGENCY LICENSURE APPLICATION**

Michigan Department of Licensing and Regulatory Affairs (LARA)  
Bureau of Health Care Services  
Health Facilities Division  
611 W. Ottawa Street, P. O. Box 30664  
Lansing, MI 48909

<b>1. Type of Health Facility/Agency</b>		
<input type="checkbox"/> Hospital	<input type="checkbox"/> Freestanding Surgical Outpatient Facility (FSOF)	
<input type="checkbox"/> Psychiatric Hospital	<input type="checkbox"/> Hospice Agency	
<input type="checkbox"/> Psychiatric Unit	<input type="checkbox"/> Hospice Residence	
<input type="checkbox"/> Psychiatric Partial Hospitalization Program		
<b>2. Type of Licensure Activity</b> (Application required by law)		
<input type="checkbox"/> Begin Operation of a New Health Facility/Agency	<input type="checkbox"/> Relocate an Existing Health Facility/Agency	
<input type="checkbox"/> Change Ownership	<input type="checkbox"/> Add Beds/Treatment Positions to a Health Facility	
<b>3. Notification</b> (Application submitted to update licensing records)		
<input type="checkbox"/> Change in Health Facility/Agency Administrator	<input type="checkbox"/> Change in Health Facility/Agency Name	
<b>4. Applicant/Licensee Name</b> [Name of corporation, partnership, or limited liability company]		
[Redacted]		
(Name of Current Licensee to Appear on License)		
[Redacted]		
(Name of Proposed Licensee to Appear on License if Change of Ownership)		
<b>5. Health Facility/Agency</b>		
[Redacted]		
(Name of Current Health Facility/Agency to Appear on License)		
[Redacted]		
(Address of Current Health Facility/Agency to Appear on License)		
[Redacted] (City)	[Redacted] (State)	[Redacted] (ZIP Code)
[Redacted]		
(Name of Proposed Health Facility/Agency to Appear on License if Changing Facility/Agency Name)		
[Redacted]		
(Address of Proposed Health Facility/Agency to Appear on License if Relocating)		
[Redacted] (City)	[Redacted] (State)	[Redacted] (ZIP Code)
<b>6. Change of Ownership</b>	[Redacted] (Effective Date) (mm/dd/yyyy)	<ol style="list-style-type: none"> <li>Change cannot occur prior to State approval.</li> <li>Enclose letter from current licensee acknowledge proposed sale of health facility/agency.</li> </ol>

<b>7. Beds/Treatment Positions</b>		<input type="checkbox"/> 7a. Proposed Increase	<input type="checkbox"/> 7b. Proposed Decrease	<input type="checkbox"/> c. Adult <input type="checkbox"/> c1. Adult/Flex <input type="checkbox"/> d. Minor *Psych only. Note that c1 is a subset of total adult beds (c).
<b>Brief Description of Bed Changes:</b>		<input type="checkbox"/>		
<b>8. Health Facility/Agency Administrator</b>				
<input type="checkbox"/> (Administrator Name)		<input type="checkbox"/> (Phone)	<input type="checkbox"/> Date of Hire (mm/dd/yyyy)	
<b>9. Federal Employer Identification Number (EIN)</b>			<b>10. Certificate of Need</b>	
<input type="checkbox"/> N/A			CON No. <input type="checkbox"/> - <input type="checkbox"/> N/A	
<b>11. Appendices – Applicable appendix must be with all new licensure applications.</b>				
<input type="checkbox"/> <b>Appendix A for Hospice Applications</b> <input type="checkbox"/> <b>Appendix B for Psychiatric Applications</b> <input type="checkbox"/> <b>Appendix B1 for Psychiatric Professional Staff</b> <input type="checkbox"/> <b>Appendix C for FSOF Waiver Pursuant to R 325.3815(4)</b>				
<p>LICENSE FEE: Do not append license fee payment to this application. A license fee invoice will be sent after application submission. This form is not used for annual renewal of license. Renewal of license is done online through the MyLicense web site (<a href="http://www.michigan.gov/elicense">www.michigan.gov/elicense</a>).</p>				
<b>Note:</b> An applicant is required to resubmit a new application if the applicant fails two pre-licensure surveys.				
<b>12. Administrator Certification (R 325.13207)</b>				
<p>By submission of this application, I certify that:</p> <ul style="list-style-type: none"> <li>• The information submitted in this application is true.</li> <li>• All phases of operation, including training programs, comply with state and federal laws prohibiting discrimination [see MCL 333.20152(1)(a)].</li> <li>• Selection and appointment of physicians to the medical staff is without discrimination on the basis of licensure or registration as doctors of medicine or doctors of osteopathic medicine and surgery [see MCL 333.20152(1)(b)].</li> </ul>				
<input type="checkbox"/> Authorized Person/Administrator			<input type="checkbox"/> (mm/dd/yyyy)	
<p>Application packet submitted by U.S. Mail should be addressed to:</p> <p>Michigan Dept of Licensing &amp; Regulatory Affairs Bureau of Health Care Services Health Facilities Division P. O. Box 30664 Lansing, MI 48909</p>			<p>Application packet submitted by a courier or overnight service should be addressed to:</p> <p>Michigan Dept of Licensing &amp; Regulatory Affairs Bureau of Health Care Services Health Facilities Division Ottawa Building, 1st Floor 611 West Ottawa Street Lansing, MI 48933</p>	
Application packet by E-mail: <a href="mailto:BHS-LC@michigan.gov">BHS-LC@michigan.gov</a>				
<p>The Michigan Department of Licensing and Regulatory Affairs will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability, or political beliefs. You may make your needs known to this Agency under the <i>Americans with Disabilities Act</i> if you need assistance with reading, writing, hearing, etc.</p>				

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**PSYCHIATRIC PROGRAM LICENSE APPLICATION  
APPENDIX B**

(Attach/Submit Appendix with BHCS-HFD-100 Form)

[Redacted] (Hospital Name)		
[Redacted] (Address)		
[Redacted] (City)	[Redacted] (State)	[Redacted] (ZIP Code)

1. Accredited	2. Name of Accrediting Organization
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<input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date: [Redacted]	[Redacted]
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If accreditation was applied for and approved or disapproved, attach a copy of the notification, including the list of recommendations. Attachment provided:  Yes

**3. Lease Arrangements**

Is the psychiatric hospital, unit or program located in leased space?  Yes  No

If yes, list the name and address of the lessor, length of lease, and any direct or indirect interest that the applicant/licensee has in the lease other than as lessee (MCL 330.1137(1)).

[Redacted]

**4. Designated Rights Advisor Information**

[Redacted] (Name of Rights Advisor)	[Redacted] (Job Title)	
[Redacted] (Phone)	[Redacted] (Hours/week dedicated to rights activities)	[Redacted] (Name of Rights Advisor Supervisor/Title)

Date of Last Recipient Rights Advisory Committee meeting: [Redacted] (mm/dd/yyyy)

Attach List of Recipient Rights Advisory Committee Members:  Yes

**5. Governing Body Certification**

By submission of this form, the Governing Body has certified that the hospital/program does not discriminate against persons on the basis of race, color, nationality, religious or political belief, sex, age, mental or physical disability, in any area of its operation, including employment, patient admission and care, and professional nonprofessional training programs.

[Redacted] Governing Body Name	[Redacted] (mm/dd/yyyy)
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## 6. Medical Director Certification

By submission of this form, the Medical Director has accepted the position and responsibility for the medical care of patients in the above named programs in compliance with Section 143 of Act 258 of the Public Acts of 1974 as amended.

 Medical Director Name	 (mm/dd/yyyy)
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## 7. Administrator Certification

By submission of this form, the Administrator certifies that:

- The information submitted in this application and all attachments are true;
- The program for which this license is being requested is operated in conformance with Sections 100a-100d, 134-150, 400-498t, 700-788, and 946 of the Mental Health Code (1974 PA 258 as amended), and the psychiatric program licensure rules 330.1201-330.1299, 330.4011-330.4089, 330.4501-330.4661, and 330.7001-330.7260;
- The program is in continuing compliance with the terms and conditions of certificate of need approval (not applicable to partial hospitalization programs); and
- Copies of the applicable psychiatric standards were provided with this application packet for licensure and agree to comply with them.

 Authorized Administrator Name	 (mm/dd/yyyy)
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## 8. REQUIRED ATTACHMENTS

(as required by Administrative Rules 330.1210 and 330.1223)

	Applicant Checklist	LARA Use Only	
		Received	Reviewed
<b>INPATIENT HOSPITAL/UNIT</b>			
a) List of stockholder names and percentage of stock owned by each	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) List of individual names composing the governing body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) List of state or national association that the hospital is a member of	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) List of procedures/practices to insure the physical health of employees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) A narrative description of the hospital program plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Inpatient program staff list: Form BHS-LC-823	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Floor plan of the space devoted to patient care and activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Written medical care plan agreement (freestanding psych hospitals only)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Current fire safety inspection report: BFS-40	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) List of related psychiatric hospitals, units or partial hospitalization program, include name, address and number of inpatient psychiatric adult and minor beds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PARTIAL HOSPITALIZATION PROGRAM			
k) A narrative description of program and schedule	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) Floor plan of the space devoted to patient care and activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m) Partial hospital staff list: Form BHS-LC-823	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n) List of related psychiatric hospitals, units or partial hospitalization program, include name, address and number of inpatient psychiatric adult and minor beds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PATIENT RIGHTS (Not required for initial licensing of partial program)			
o) Self-Attestation Checklist (see MCL 330.1752)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p) Annual or semi-annual Recipient Rights reports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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**PSYCHIATRIC PROFESSIONAL STAFF REPORT  
APPENDIX B-1**  
(Attach/Submit Appendix with BHCS-HFD-100 Form)

Rule 330.1223(f) requires applicants to file current staffing patterns and list of employees involved in the professional care and treatment of patients, with their respective license or certification numbers with the date of expiration.

[Redacted] (Hospital Name)		
[Redacted] (Address)		
[Redacted] (City)	[Redacted] (State)	[Redacted] (ZIP Code)

Staffing Categories	Adult (18 yrs of age or Older)			Minor (17 yrs of age or younger)		
	Budgeted FTE Positions Filled	Budgeted FTE Positions Vacant	Privileged Staff Not Salaried/ Contract	Budgeted FTE Positions Filled	Budgeted FTE Positions Vacant	Privileged Staff Not Salaried/ Contract
Medical Director	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Psychiatrist	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Child Psychiatrist	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Internist	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Pediatrician	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Registered Nurse, MSN	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Registered Nurse	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Licensed Practical Nurse	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Aide/MHW/MHT	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Psychologist/Licensed	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Teacher MA/BA/BS	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Art/Music/Recreation Therapist	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Occupational Therapist	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Certified Occup. Therapist Aide	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Social Worker/LMSW	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Social Worker/LBSW	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Other: [Redacted]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

**PROFESSIONAL STAFF**

Duplicate page as needed (Page  of )

Name		Title	Full-time = FT Part-time = PT Contract = CT	License or Certification	Expiration Date (mm/dd/yyyy)
1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
6	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
7	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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9	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
10	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
11	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
12	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
13	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
14	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
15	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
16	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
17	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
18	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
19	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
20	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
21	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
22	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
23	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
24	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
25	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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