

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 Community and Health Systems
Health Facilities Division
611 W. Ottawa Street, P. O. Box 30664
Lansing, MI 48909

1. Type of Health Facility/Agency		
<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		
2. Type of Licensure Activity (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	
3. Notification (Application submitted to update licensing records)		
<input type="checkbox"/> Change in Health Facility/Agency Administrator	<input type="checkbox"/> Change in Health Facility/Agency Name	
4. Applicant/Licensee Name [Name of corporation, partnership, or limited liability company]		
[Redacted]		
(Name of Current Licensee (owner) to Appear on License – ie, ABC Healthcare, LLC)		
[Redacted]		
(Name of Proposed Licensee to Appear on License if Change of Ownership)		
5. Health Facility/Agency		
[Redacted]		
(Name of Current Health Facility/Agency to Appear on License – This is the doing business as/DBA name)		
[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)
6. Change of Ownership	[Redacted] (Effective Date) (mm/dd/yyyy)	1. Change cannot occur prior to State approval. 2. Enclose letter from current licensee acknowledge proposed sale of health facility/agency.

7. Beds/Treatment Positions		<input type="text"/> 7a. Proposed Increase	<input type="text"/> 7b. Proposed Decrease	<input type="text"/> c. Adult <input type="text"/> c1. Adult/Flex <input type="text"/> d. Minor *Psych only. Note that c1 is a subset of total adult beds (c).
Brief Description of Bed Changes:		<input type="text"/>		
8. Health Facility/Agency Administrator				
<input type="text"/> (Administrator Name)		<input type="text"/> (Phone)	<input type="text"/> (Email)	<input type="text"/> Hire Date (mm/dd/yyyy)
9. Federal Employer Identification Number (EIN)			10. Certificate of Need	
<input type="text"/> <input type="checkbox"/> N/A			CON No. <input type="text"/> - <input type="text"/> <input type="checkbox"/> N/A	
11. Appendices – Applicable appendix must be with all new licensure applications.				
<input type="checkbox"/> Appendix A for Hospice Applications <input type="checkbox"/> Appendix B for Psychiatric Applications <input type="checkbox"/> Appendix B1 for Psychiatric Professional Staff <input type="checkbox"/> Appendix C for FSOF Waiver Pursuant to R 325.3815(4)				
<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 (www.michigan.gov/elicense).</p> <p>Note: An applicant is required to resubmit a new application if the applicant fails two pre-licensure surveys or does not complete the licensure process within one year from the date the application is deemed complete.</p>				
12. Administrator Certification (R 325.13207)				
<p>By submission of this application, I certify that:</p> <ul style="list-style-type: none"> The information submitted in this application is true. All phases of operation, including training programs, comply with state and federal laws prohibiting discrimination [see MCL 333.20152(1)(a)]. 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)]. 				
<input type="text"/> Authorized Person/Administrator			<input type="text"/> (mm/dd/yyyy)	
Application packet submitted by U.S. Mail should be addressed to: Michigan Dept of Licensing & Regulatory Affairs Bureau of Community and Health Systems Health Facilities Division P. O. Box 30664 Lansing, MI 48909			Application packet submitted by a courier or overnight service should be addressed to: Michigan Dept of Licensing & Regulatory Affairs Bureau of Community and Health System/Health Facilities Division Ottawa Building, 1st Floor 611 West Ottawa Street Lansing, MI 48933	
Application packet by E-mail: robinsonk18@michigan.gov				
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.				