MICHIGAN DEPARTMENT OF LICENSING & REGULATORY AFFAIRS
BUREAU OF COMMUNITY & HEALTH SYSTEMS
HEALTH FACILITIES DIVISION
SPECIALIZED HEALTH SERVICES SECTION

RHC PROGRAM – SUPPLEMENTARY APPLICATION INFORMATION

Clinic Name

Clinic Address

City, State & Zip

Clinic Phone No.

Business Fiscal Year End (Month/Day)

Do Not Write in These Boxes

X	***Necessary Items to Include with Application***	*Y*	*N*	***Notes***
	Clinic's contact name and their position: Name: Position: Phone: Fax:			
	Clinic's phone and fax numbers: Phone: Fax:			
	Is the clinic provider-based: ☐ Yes ☐ No If yes, identify provider's CMS CCN #:			
	Map of the clinic location with detailed directions on travel from Lansing. *Identify attachment as Attachment #1.*			
	Floor plan of the facility. *Identify attachment as Attachment #2.*			
	Clinic's days and hours of operation:			
	Resumes for all physician(s), physician assistant(s), and /or nurse Practitioner(s). *Identify attachment as Attachment #3.*			
	Minutes of the most recent meeting of the governing body and the advisory group of professional personnel. *Identify attachment as Attachment #4.*			