NON-LONG TERM CARE STATE LICENSING

HEALTH FACILITY LICENSURE APPLICATION & CHANGE REQUEST

Submit form to: LARA-BCHS-NLTCSLS@michigan.gov

1. Applicant/Licensee Information			
Applicant Name (Corporate Name):			
Name of License (Facility/DBA Name - Do not include LLC, Inc., etc.):			
License Number (required if currently licensed):	Federal Employer Identification # (EIN):		
License Site Address:			
City:	State: MI	Zip Code:	Facility Phone Number:
Mailing Address (only if different than license address: all correspondence & license will be mailed to this location):			
City:	State:	Zip Code:	
Administrator Name:			
Phone:	Email:		

2. Health Facility Type (only select 1 facility type per form)	
Hospital	Hospice Agency
Psychiatric Hospital/Unit (if new application, must complete pages 4&5)	Hospice Residence (Include license # of hospice agency for at least the immediate preceding 2 years)
Freestanding Surgical Outpatient Facility	

3. Type of Change Request or Licensure Action (see section 5 regarding payment information)	
New Application	Change in License (facility/DBA) Name
Relocation	Change in Bed Designation
Change of Ownership or Corporate Name	Change in Bed Capacity

Change in License (Facility/DBA) Name	Proposed Effective Date:
Current License (Facility/DBA) Name:	
Proposed License (Facility/DBA) Name:	

Change in Ownership (CHOW) or Corporate Name	Proposed Effective Date:
Current Corporate Name:	
Proposed Name of License	
New Federal Employer Identification # (EIN) if applicable:	

Relocation	Proposed Effective Date:
Address of Current License Facility:	
Address of Proposed License Facility:	

Bed Designation and Capacity	Proposed Effective Date:

Hospital (Acute) Beds

Bed Type (*bed type is a subcategory)	Current # of Beds	Proposed # addition/ decrease beds	Proposed New Total # of Beds
A. MED/SURGICAL (includes Med/Surg, Rehab & ICU)			
*Rehabilitation Beds			
*Intensive Care Unit (ICU) Beds			
*Short Term Stay (Swing) Beds			
B. OBSTETRICAL			
C. PEDIATRIC (includes pediatric & NICU beds)			
*Neonatal Intensive Care Unit (NICU) Beds			
TOTAL Number of Licensed Beds (A+B+C)			

Brief Description of Bed Designation/Capacity Changes

Psychiatric Beds

Bed Type (*bed type is a subcategory)	Current # of Beds	Proposed # addition / decrease beds	Proposed New Total # of Beds
A. Inpatient Psychiatric (includes adult, child & flex)			
*Adult Beds			
*Flex Beds (Adult/Child)			
*Child Beds			
Total Number of Licensed Beds (A only)			

Brief Description of Bed Designation Capacity/Changes:

4. Certificate of Need (CON) - Required for a new facility, increase in beds, CHOW, and/or relocations (license/facility name and address in this application must match approved CON)

CON Number:	Approval Date:
CON Number:	Approval Date:

5. Fee Schedule and Payments

Fees for New a License		Fees for Changes to an Existing License/Facility	
FSOF	$2500	License (DBA/Facility) Name Change	$500
Hospital	$2500 plus $10/bed	CHOW or Corporate Name Change	$500
Hospice Agency	$2500	Relocation	No Fee
Hospice Residence	$2500 plus $5/bed	Bed Designation Change	No Fee
Psychiatric Hospital	$500 plus $10/bed	Bed Capacity Decrease	No Fee
Substance Use Disorder	$500	Bed Capacity Increase	$500 plus $10/bed hospital & psych and $5/ bed hospice residence

To make an electronic payment for a new license: New Application Electronic Payment

To make an electronic payment for a change to an existing license:Change Request Electronic Payment

To send a hand written check to the Department for a new license or change to existing license, go back to the website for mailing instructions. Please note that this method can take 4-6 weeks for processing.

Indicate which method you have chosen and fee amount you are submitting

Electronic Amount Paid $

Mailed written check Amount Paid $

6. Administrator Certification

The undersigned certifies the information supplied is accurate and true:

Authorized Person/Administrator:	Date:

Submit Application to: LARA-BCHS-NLTCSLS@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 *Americans with Disabilities Act* if you need assistance with reading, writing, hearing, etc.

Psychiatric Professional Staff Report

<u>Only New Psychiatric Facilities</u> must complete pages 4 and 5

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

Staff 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/ Contracted	Budgeted FTE Positions Filled	Budgeted FTE Positions Vacant	Privileged Staff Not Salaried/ Contracted
Medical Director						
Psychiatrist						
Child Psychiatrist						
Internist						
Pediatrician						
Registered Nurse, MSN						
Registered Nurse						
Licensed Practical Nurse						
Aide/MHW/MHT						
Psychologist						
Teacher MA/BA/BS						
Art/Music/Recreation Therapist						
Certified Occup. Therapist Aide						
Social Worker/LMSW						
Social Worker/LBSW						
Other						

Psychiatric Professional Staff Report Cont'd (duplicate pages as needed)					
Name		Title	Full-Time=FT Part-Time=PT Contract=CT	License or Certification	Expiration Date
1					
2					
3					
4					
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