



Non-Long-Term Care State Licensing

Health Facility Licensure Application & Change Request Invoice

Applicant or Licensee Information		
Applicant or Licensee Name:		
License Number (required if currently licensed):		
License Site Address:		
City:	MI	Zip Code:
Contact Name:	Phone Number:	
Contact Email:		

*Remittance of any fee(s) must occur before licensing action can be finalized

Applicants Only - Select the health facility type that you are applying for		
Facility Type	Sigma Account	Applicable Fees
Freestanding Surgical Outpatient Facility	641R9513001	\$2,500
Hospital	641R9512001	\$2,500 plus \$10/bed
Hospice Agency	641R9509001	\$2,500
Hospice Residence	641R9510001	\$2,500 plus \$5/bed
Psychiatric Hospital/Unit	641R9516001	\$500 plus \$10/bed
Substance Use Disorder Program	641R9508001	\$500

Existing Licensee Only - Change Request - Select the health facility and type of change requested		
Type of Facility	Change Request and Fees	
Freestanding Surgical Outpatient Facility	License (DBA) Name Change	\$500
Hospital	CHOW/Corporate Name Change	\$500
Hospice Agency	Relocation	\$500
Hospice Residence	Bed Designation Change	No Fee
Psychiatric Hospital/Unit	Bed Designation Decrease	No Fee
Substance Use Disorder Program	Bed Capacity Increase	\$500 plus \$10/bed hospital & psych or \$5/bed hospice residence

Applicant/Licensee Fee Remittance
Amount:
Check #:

This Area for Revenue Services Unit Only