# BUREAU OF COMMUNITY AND HEALTH SYSTEMS
# NON-LONG-TERM CARE HEALTH FACIITIES
# STATE LICESNSURE APPLICATION & CHANGE REQUEST

## 1. Applicant/Licensee Information

| | | | |
|---|---|---|---|
| Facility/Doing Business As (DBA) Name (current if licensed, proposed if new applicant, do not include LLC, Inc., etc.): | | | |
| Applicant/Licensee Name (corporate name: include if same or different than facility/DBA name): | | | |
| State License Number (required if currently licensed): | Federal Employer Identification # (EIN): | | |
| License Site Address (current address if licensed, proposed if new applicant): | | | |
| 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 Number: | Email: | |

## 2. Health Facility Type (select only 1 facility type per form)

- ☐ Hospital
- ☐ Psychiatric Hospital/Unit
- ☐ Freestanding Surgical Outpatient Facility (FSOF)
- ☐ Hospice Agency
- ☐ Hospice Residence (must provide state license # of hospice agency that has been licensed for 2 years)

## 3. Licensure Action

- ☐ New Application
- ☐ Relocation
- ☐ Change in Facility/DBA Name (license name)
- ☐ Change of Ownership or Licensee/Corporate Name
- ☐ Closure
- ☐ Change in Bed Designation
- ☐ Change in Bed Capacity
- ☐ Building Program Agreement (BPA)

Temporary Bed Delicensure & Relicensure under MCL 333.21551 located on Hospital website

## 4. Certificate of Need (CON) *approval letter must be attached (if applicable)

| | | | |
|---|---|---|---|
| CON#: | Approval Date: | CON#: | Approval Date: |

## 5. Bed Designation and Capacity

| HOSPITAL BEDS | Proposed Effective Date | | |
|---|---|---|---|
| | Current # of Beds | Proposed increase/ decrease | New Proposed Total # Beds |
| Licensed Beds | | | |
| Building Program Agreement (BPA) | | | |
| Emergency (under 333.22235 or EO) | | | |
| Total Licensed Beds | | | |
| Brief Description of Bed Changes: | | | |

| PSYCHIATRIC BEDS | Proposed Effective Date | | |
|---|---|---|---|
| | Current # of Beds | Proposed increase/ decrease | New Proposed Total # Beds |
| Adults Beds | | | |
| Child/Adolescent | | | |
| Building Program Agreement (BPA) | | | |
| Emergency Beds (under 333.22235 or EO) | | | |
| Total Licensed Beds | | | |
| Brief Description of Bed Changes: | | | |

| HOSPICE RESIDENCE BEDS | Proposed Effective Date | | |
|---|---|---|---|
| | Current # of Beds | Proposed increase/ decrease | New Proposed Total # Beds |
| Licensed Beds | | | |

| 6. Change in Facility/DBA (License) Name | Proposed Effective Date: |
|---|---|
| Current Facility/DBA (License) Name: | |
| Proposed Facility/DBA (License) Name: | |

| 7. Change in Ownership(CHOW) ☐<br>(Bill of sale and/or purchase agreement will be required at time of CHOW)<br>Corporate/Licensee Name Change ☐ | Proposed Effective Date: |
|---|---|
| Current Licensee/Corporate Name: | |
| Proposed Licensee/Corporate Name: | |
| New Federal Employer Identification # (EIN): | |

| 8. Relocation | Proposed Effective Date: |
|---|---|
| Address of Current Licensed Facility: | |
| Proposed Address of Licensed Facility: | |

| 9. Closure | Proposed Closure Date: |
|---|---|
| Patient census at the time this closure notification: | |
| Individual who is designated by the governing body to serve as the contact person for the closure:<br>Name:<br>Email: Phone Number: | |
| Date the closure plan checklist and closure plan was submitted to the Department in accordance with administrative rule R 325.45169: | |

**10. Fees & Payment (all payments & applications must be submitted electronically with links provided below)**

| Click here New Licensure for payment | | Click here Licensure Change(s) for payment | |
|---|---|---|---|
| FSOF | $2,500 | License DBA/Facility Name Change | $500 |
| Hospital | $2,500 plus $10/bed | CHOW or Corporate Name Change | $500 |
| Hospice Agency | $2,500 | Relocation | $500 |
| Hospice Residence | $2,500 plus $5/bed | BPA | $500 |
| Psychiatric Hospital/Unit | $500 plus $10/bed | Bed Capacity Increase (no fee for bed decrease) | $500 plus<br>$10/bed (hospital)<br>$10/bed (psych)<br>$5/bed (hospice residence) |

**11. Certification: For initial licensure, must be signed by the owner or licensee. For licensure changes, an authorized representative may sign under the requirements set forth in MCL 333.20102**

The undersign certifies that all of the information provided is accurate; that all phases of operation, including training programs, comply with state and federal laws prohibiting discrimination; and selection and appointment of physicians to its medical staff is without discrimination on the basis of licensure or registration as doctors of medicine or doctors of osteopathic medicine and surgery ***(an applicant or licensee who makes a false statement in an application or statement required by the department pursuant to this article is guilty of a felony, punishable by imprisonment for not more than 4 years, or a fine of not more than $30,000.00, or both.)***

Licensee or Authorized Representative Signature: _____ Date:

**SUBMIT TO: LARA-BCHS-NLTCSLS@MICHIGAN.GOV**