ARKANSAS STATE BOARD OF HEALTH
HEALTH FACILITY SERVICES
5800 West Tenth, Suite 400
Little Rock, AR 72204-1704

APPLICATION FOR LICENSE TO CONDUCT A HOSPITAL OR RELATED INSTITUTION

Act 414 of 1961 As Amended
Act 509 of 1983
Act 283 of 1983
Act 980 of 1985
Act 956 of 1987
Act 920 of 1991
Act 891 of 1997
Act 59 of 2023

New Application ☐
Change of Ownership ☐

NOTE: Before beginning this Application, please read carefully the attached instructions.

For Departmental Use Only

Effective Date: _____ **Expiration Date:** _____

License Number _____ **Certificate Number** _____

Facility No. _____ **Customer Number** _____

Total Bed Capacity _____ **(Total Includes** _____ **Rehab. Unit Beds** _____**Psy. Unit Beds)**

Fee Collected $_____ **License Granted** _____

Type of License _____

I. Name and Location.

Full Name of Health Care Facility (Legal & Doing Business As (DBA)					
Physical Address					
City		**State**		**Zip Code**	
County		**Phone No.**		**Administration Fax No.**	
Mailing (Correspondence) Address					
City		**State**		**Zip Code**	
Email Address		**Contact Person:**			

II. Classification Type. (Check in unshaded box type of License for which you are applying.)

A. Hospital:		General ☐ CAH ☐ LTAC
		Surgery & General Medical Care ☐ CAH ☐ LTAC
		Maternity and General Medical Care
		Psychiatric
		Rehabilitation
		Rural Emergency Hospital
B. Related Institution:		Infirmary
		Recuperation Center
		Outpatient Surgery Center
		Outpatient Psychiatric Center
		Alcohol & Drug Abuse Unit (Hospital-Based)
		Alcohol & Drug Abuse Facility (Free-Standing)
C. Private Care Agency		Medicaid Personal Care
D. Home Health: (Check only one class type, then check applicable services your agency is licensed to provide in box below.)		Class A (Medicare Certified)
		Class B (Non-Medicare Certified)
		Derivative B
For Home Health Only: Check all applicable services provided for the licensed type selected above.		Intermittent Skilled Care
		Extended Care
		Personal Care
F. Other:		Specify:
		Hospice
		In Vitro Fertilization Clinic
		Free-Standing Birthing Center

III. Ownership Type. (Check **Only** One)

Check in unshaded box Type of Ownership.		
Public		State **If checked, complete all remaining Sections except V & VI.**
		County **If checked, complete all remaining Sections except V & VI.**
		City **If checked, complete all remaining Sections except V & VI.**
Private		Sole Proprietorship **If checked, complete all remaining Sections except IV & VI.**
		Partnership (**all types**) **If checked, complete all remaining Sections except IV & V.**
		Corporation/Company (**all types**) **If checked, complete all remaining Sections except IV, V & VI.**

IV. Complete only if ownership displayed in Section III (above) is State, County or City.

Name and title of individual who is the head of the governmental department having jurisdiction over the facility (i.e. Chairman of County Board or City Commission).	
Name	**Title**

V. Complete only if ownership displayed in Section III (above) is Sole Proprietorship.

Name and address of sole proprietor.	
Name	**Address**

VI. Names and Addresses of Partners. (Complete only if ownership displayed in Section III (on page 3) is Partnership, General Partnership, Limited Partnership, Limited Liability Partnership or Limited Liability Limited Partnership.) Please attach a list.

VII. Names, address(es) and phone numbers of the Board of Directors, Governing Body or Committee of the Whole. Please attach a list.

VIII. Facility Ownership Information. Please identify the owner/entity reflected in Section III (on page 3), i.e., if Corporation was selected, please identify the name, address and phone number of the Corporation. Note: Not owner of building.

Name	Address	Phone No.

IX. Facility Management. Do you have a contract with an entity to manage your facility? _____Yes_____No
If yes, please complete the requested information below.

Name	Address	Phone No.

X. Fiscal Year Ending Date. _____ /_____ (Month/Day)

XI. General.

A. Bed Capacity.

(1) How many beds are requested in this Application?_____(Excluding bassinets and labor beds.)

(2) If this total is different from that for which you currently are licensed, explain:

XII. For Change of Ownership Applications Only: Is your facility accredited?____Yes ___No

If accredited, list Accrediting Organization (AO) _____

AO Granted Deemed Status?____Yes ___No

If AO Granted Deemed Status, please provide documentation from AO of deemed status.

Deemed Medicare status with Medicare health and safety standards through a survey conducted by a CMS-approved Accreditation Organization. If you were Medicare certified by Health Facility Services, Department of Health, please respond with a "No" to the question "Is your facility accredited?".

XIII. Administrator Name.

XIV. Certification and Verification.

I hereby certify that I have read the aforementioned Application and that all statements are true to the best of my knowledge and belief. I am aware that any willful misrepresentation of any material fact contained on this application will subject me to penalties as prescribed in the Arkansas Licensing Laws including, but not limited to revocation and/or suspension of this License.

Type or print names of authorized person(s) in accordance with attached instructions.	Signature(s)

Subscribed and sworn to before me this the _____ day of_____, 20___.

(Notary Seal)

My commission expires on_____, 20___.

Notary Public