Instructions for Completion of the Medical Care Facility Licensure Application

Please read the instructions carefully.

I. *IDENTIFICATION:*

A. Check classification as defined under KSA 65-425. **A critical access hospital must also meet the requirements of KSA 65-468 et seq.**

B. Provide the full legal name and physical address of the facility including the nine-digit zip code.

Provide the facility's telephone number, fax number and e-mail address.

C. Identify the person designated by the governing authority to be responsible for the daily management of the facility. This person is usually referred to as the administrator/chief executive officer.

II. *CONTROL AND GOVERNING AUTHORITY:*

A. Read the information 1 thru 5 to complete Part II. Identify the disclosing entity type, as it is registered with the Kansas Secretary of State's Office; or if the disclosing entity is government or county owned please indicate. List or attach the governing information, list the names, titles percentage of ownership and addresses.

B. Give the legal names of the organization that owns and or controls this medical care facility.

III. *GENERAL INFORMATION:*

A. **FOR HOSPITALS ONLY:** "General beds", includes medical-surgical, rehabilitation, psychiatric, etc.

B. The active medical staff or the physician and dentist members who provide the preponderance of medical practice in the facility and perform all significant medical staff organizational and administrative functions.

C. For licensure renewal purposes, provide the most recent survey and approval letter from the CMS approved accrediting organization if applicable to your facility.

D. **COMPLETE THIS ITEM ONLY IF ANSWERING "YES" TO ITEM III.** If a survey has been conducted during a 12-month period prior to the date of application but the survey results and copy of the survey report have not been received, mark "NO". If the survey was conducted more than 12 months before the application date but the results and survey report were received during the 12-month period, mark 'yes' and **submit the report.**

E. The term "organized" relative to a clinical department or service is one that is an organizational unit or a functional division of the facility or medical staff.

F. Clinical Laboratory Improvement Act (CLIA) certification.

* The red notations are new questions that may require submission of documentation.

Select One:
☐ Initial
☐ Annual Renewal
☐ Change of Owner
☐ Amended _____

Kansas Department of Health and Environment
Bureau of Community Health Systems & Health Facilities Program
Medical Care Facility Licensure Application
Initial; Annual Renewal; Change of Ownership or Amended Application

Health Facilities Program

Medical Care Facility Identification:

A. ***Classification of License select one:*** ☐ General Hospital ☐ Critical Access Hospital ☐ Special Hospital ☐ Ambulatory Surgery Center

B. ***Name of Medical Care Facility:*** _____

Address: _____ City: _____

Zip Code: _____ Public Phone: _____ Fax: _____

Web Address: _____

** Ambulatory Surgery Centers List Days and Hours of Operations for this ASC:*

Days Open: _____ Operation Hours: _____

Administration Information:

C. Chief Executive Officer or Administrator: Title:

Desk phone _____ Email address _____

* Chief of Medical Staff: _____

Email address: _____ Phone: _____

* Director *or* Risk Manager Name: _____

Email address: _____ Phone: _____

_____ ***Do Not Write Below This Line, State Agency Use Only*** _____

Effective Date _____ Facility I.D. Number _____

Renewal Date _____ Reviewed By _____

***Ownership Information*:**

Select the Disclosing Entity type as it is registered with the Kansas Secretary of State's Office and submit the Certificate of Good Standing from the Kansas Secretary of State's Office.

1. List the name(s) and addresses of each person who has any direct or indirect ownership of **5 percent** or more in this entity.

2. List each person who is the owner (in whole or in part) of any mortgage, deed of trust, note or other obligation secured (in whole or in part) by such facility or any of the property or assets of such facility.

3. If the disclosing entity is organized as a corporation, attach a list showing the names and address of each Officer and or Director.

4. If the disclosing entity is organized as a limited partnership or limited liability company, please describe each limited liability for each 5 percent owner, and for all general partners.

5. If the disclosing entity is a governmental unit, attach a list showing the names and addresses of each responsible official (i.e., county commissioner).

***II. CONTROL AND GOVERNING AUTHORITY**:*

A. Disclosing Entity's Name: _____

Physical Address: _____
City/State Zip code

B. *Type of Entity:* ☐ Corporation for profit ☐ Corporation non-profit

☐ Limited Liability Company (LLC) ☐ Professional Associates (P.A.)

☐ Government/County _____ ☐ Other (Explain) _____

Print Name	Title	Ownership %	Address
Print Name	Title	Ownership %	Address
Print Name	Title	Ownership %	Address
Print Name	Title	Ownership %	Address
Print Name	Title	Ownership %	Address
Print Name	Title	Ownership %	Address

General Information:

A. ***(FOR HOSPITALS ONLY)*** Number of Beds: General beds _____ Observation beds _____

Swing beds _____ IPPS beds _____ LTC _____ Bassinets _____

B. Number of Active Medical Staff _____

C. ***Check the box that applies:***

☐ This applicant is licensed only
☐ This applicant is licensed, accredited
☐ This applicant is licensed, accredited and deemed to participate in Medicare by an approved accrediting organization.

D. Specify the Accrediting Organization _____ and provide the current accrediting organization full survey with the decision letter.

Provide the accreditation effective dates _____

*Submit copy of the (MCF) Certificate of Professional Liability Insurance i.e., the Declaration Letter.

E. The licensing regulations include standards for optional organized services, departments, or units. Check the boxes below that are provided by your facility. * Please submit the completed hospital database and or the ASC updated information worksheet.

☐ Surgery department
☐ Obstetrical department
☐ Outpatient department
☐ Pediatric department
☐ Long Term Care Unit
☐ Intensive coronary care units
☐ Radiology
☐ Social Services
☐ Psychiatric Services
☐ Dialysis Services
☐ Physical Therapy
☐ Occupational Therapy
☐ Inhalation/respiratory Therapy

F. Does this facility hold a valid Clinical Laboratory Improvement Act (CLIA) certificate _____, please submit copy a of the current CLIA Certificate of Registration.

(Initials) _____ I the undersigned is authorized to represent the governing body, corporation, organization, individual, or partnership in whom is vested the responsibility for operation of the facility and certifies that the above information is true and correct.

I understand that this application may be subject to release pursuant to the Kansas Open Records Act (K.S.A. 45-215 et seq.).

_____ _____
Print Name Title Signature

_____ _____
Phone number Date

The undersigned hereby applies to the Kansas Department of Health and Environment for a license to operate this medical care facility is subject to provisions under the Kansas Law. **Return completed application & documentation** to:

: KDHE / Health Facilities Program
Acute & Continuing Care
1000 SW Jackson St., Suite 330
Topeka, Kansas 66612
Phone Number (785) 296-0127 Fax Number (785) 559-4250