LARA
LICENSING AND REGULATORY AFFAIRS

COMMUNITY AND HEALTH SYSTEMS

NON-LONG-TERM CARE HEALTH FACILITIES STATE LICENSURE APPLICATION & CHANGE REQUEST

1. Applicant/Licensee Information

Facility/DBA Name (License Name: current name 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:		
Email:			

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

- ☐ Hospital
- ☐ Psychiatric Hospital/Unit
- ☐ Freestanding Surgical Outpatient Facility
- ☐ Hospice
- ☐ Hospice Residence _____ (hospice agency license # licensed for 2 yrs)

3. Type of Change Request or Licensure Action (see section 9 regarding payment information)

- ☐ New Application
- ☐ Relocation
- ☐ Change of Ownership or Licensee/Corporate Name
- ☐ Temporary Bed Delicensure under MCL 333.21551 (nonurbanized hospital or rural emergency hospital must complete page 4)
- ☐ Change in Facility/DBA Name (License Name)
- ☐ Change in Bed Designation
- ☐ Change in Bed Capacity
- ☐ Temporary Bed Relicensure under MCL 333.21551 (must complete page 5)

4. Bed Designation and Capacity

HOSPITAL BEDS

Proposed Effective Date: / Bed Type (*indicates a subcategory)	Current # of Beds	Proposed # of increase/ decrease	Proposed New Total # Beds
A. Med/Surgical (includes Med/Surg, Rehab, ICU & Swing)			
* Rehabilitation Beds			
* Intensive Care Unit (ICU) Beds			
* Swing Beds (Short Term Stay)			
B. Obstetrical			
C. Pediatric			
* Neonatal Intensive Care Unit (NICU) Beds			
D. Emergency (under 333.22235 or EO)(**must attach floor plans**)			
Total Number of Licensed Beds (A+B+C+D)	0	0	0

Brief Description of Bed Designation/Capacity Changes:

PSYCHIATRIC BEDS

Proposed Effective Date: / Bed Type (*indicates a subcategory)	Current # of Beds	Proposed # of increase/ decrease	Proposed New Total # Beds
A. Adult Beds			
B. Geriatric Beds			
C. Adult Developmental Disability Beds			
D. Adult Medical Psychiatric Beds			
E. Adult High Acuity Beds			
F. Adolescent Beds			
G. Adolescent Developmental Disability Beds			
H. Adolescent Medical Psychiatric Beds			
I. Adolescent High Acuity Beds			
J. Emergency (under 333.22235 or EO)(**must attach floor plans**)			
Total Number of Licensed Beds (A+B+C+D+E+F+G+H+I+J)	0	0	0

Brief Description of Bed Designation/Capacity Changes:

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

6. Change in Ownership(CHOW) ☐ Corporate/Licensee Name Change ☐	Proposed Effective Date:
Current Licensee/Corporate Name:	
Proposed Licensee/Corporate Name:	
New Federal Employer Identification # (EIN):	

7. Relocation	Proposed Effective Date:
Address of Current Licensed Facility:	
Address of Proposed Licensed Facility:	

8. Certificate of Need (CON) *approval letter must be attached if applicable			
CON#:	Approval Date:	CON#:	Approval Date:

9. Fees and Payment

Fees for New License	
FSOF	$2500
Hospital	$2500 plus $10/bed
Hospice Agency	$2500
Hospice Residence	$2500 plus $5/bed
Psychiatric Hospital/ Unit	$500 plus $10/bed
Substance Use Disorder	$500

Fees for Changes to Existing License	
License (DBA/Facility) Name Change	$500
CHOW or Corporate Name Change	$500
Relocation	$500
Bed Designation Change	No Fee
Bed Capacity Increase (includes emergency/temp)	$500 plus n $10/hospital&psych bed n $5/hospice resident bed
Bed Capacity Decrease	No Fee

Electronic payment New Licensure Application Electronic payment Changes to Existing License

(payments can be made either via credit card or electronic check)

Indicate the method chosen and fee amount submitted:

☐Electronic - Amount Paid: ☐Mailed Written Check - Amount Paid:

(mailing instructions with 4-6 weeks processing time)

SUBMIT APPLICATION TO: LARA-BCHS-NLTCSLS@MIGHIGAN.GOV

10. Administrator Certification

The undersign certifies that all of the information provided is accurate and true

Administrator Signature: Date:

Temporary Bed Delicensure under MCL 333.21551
(nonurbanized hospital or rural emergency hospital (REH))

1. Request to Temporarily Delicense Beds

☐ Reduction (not more than 50% of licensed beds)	☐ REH (100% licensed bed reduction)

2. Attestation of Nonurbanized Area (must provide proof of conversion from center for medicare/medicaid (CMS) for REH conditions of participation)

I, (administrator), attest that (hospital name) is located in a nonurbanized area as defined under MCL 333.21551.

3. Bed Capacity and/or Designation Information

Bed Type	Current # of Licensed Beds	Proposed # of beds to be temporarily delicensed	Proposed New Total # of beds
A. Med/Surg			
B. Obstetrical			
C. Pediatric (includes ped & NICU beds)			
Total Number of Licensed Beds (A+B+C)			

Location of the specific beds to be temporarily delicensed (must include floor plans):

Proposed alternative use for space previously occupied by the temporarily delicensed beds:

4. Temporary Bed Delicensure Timeframe (not to exceed 5 years)

Proposed Begin Date:	Proposed End Date:

5. Extension Request for Temporary Delicensed Beds (cannot more than 5 additional years)

Date original delicenusure granted:	New proposed expiration date:

6. Administrator Certification

The undersign certifies that all of the information provided is accurate and true

Administrator Signature: Date:

Temporary Bed Relicensure under MCL 333.21551
(nonurbanized hospital or rural emergency hospital (REH))

1. Request to Relicense Beds

☐ Reduction (not more than 50% of licensed beds)	☐ REH (100% licensed bed reduction)
Proposed Relicensure Date(request must be made at least 90 days prior to relicensure):	

2. Attestation of Relicensed Bed Space

I, (administrator), attest that (hospital name), space for the relicensed beds is in compliance with Public Health Code, Act 368 of 1978, Part 215 and the rules promulgated under this article, including all licensure standards in effect at the time of relicensure, or the hospital has a plan of correction that has been approved by the Department.
Health Facilities Engineering Section must approve space prior to relicensure.

3. Bed Capacity and/or Designation Information

Bed Type	Current # of Licensed Beds	Proposed # of beds for relicensure	Proposed New Total # of beds
A. Med/Surg			
B. Obstetrical			
C. Pediatric (includes ped & NICU beds)			
Total Number of Licensed Beds (A+B+C)			

Location of specific beds to be relicensed (must include floor plans):

Notes/Additional Information:

4. Administrator Certification

The undersign certifies that all of the information provided is accurate and true

Administrator Signature: Date: