LARA Use Only Facility Number

STATE OF MICHIGAN
Michigan Department of Licensing and Regulatory Affairs (LARA)
Bureau of Community and Health Systems

HEALTH FACILITY/AGENCY LICENSURE APPLICATION

1. Type of Health Facility/Agency

☐ Hospital	☐ Hospice Agency
☐ Psychiatric Hospital/Unit	☐ Hospice Residence
☐ Freestanding Surgical Outpatient Facility (FSOF)	☐ Nursing Homes, County Medical Care Facilities, Hospital Long Term Care Units

2. Type of Licensure Activity (Fee and Applicable Appendices Required, see #10)

☐ Begin Operation of a New Health Facility/Agency*	Proposed Operational Date:
☐ Change Ownership (CHOW)	Proposed Date of CHOW:
☐ Change in Bed Capacity (Add/Delete Beds)	Proposed Effective Date:

* An application fee ($2,000) must be submitted with the application when beginning operation of a new health facility/agency (not applicable for psychiatric hospitals/units). This application fee is not the licensing fee ($500) and any applicable bed fee(s), both will be assessed and invoiced under separate cover when applicable.

3. Notification (No Fee Required or Appendices Necessary Unless Specified)

☐ Relocate an Existing Health Facility/Agency	Proposed Relocation Date:
☐ Change in Health Facility/Agency Name	Proposed Name Change Date:
☐ Change in Bed Designations (Complete Appendix D)	Proposed Bed Change Date:

4. Applicant/Licensee Name (Owner)

Name of Current Licensee (owner) – e.g., ABC Healthcare, LLC	Federal Employer Identification Number (EIN)
Name of Proposed Licensee if Change of Ownership	Federal Employer Identification Number (EIN)

5. Health Facility/Agency

Name of Current Health Facility/Agency – i.e., This is the doing business as (DBA) name		
Address of Current Health Facility/Agency		
City	State	ZIP Code
Name of Proposed Health Facility/Agency if Changing Facility/Agency Name		
Address of Proposed Health Facility/Agency if Relocating		
City	State	ZIP Code

6. Administrator (All Applicants) / Director of Nursing (Nursing Home Applicants Only)

Administrator Name	Phone	Email	License Number – Nursing Homes Only
Director of Nursing (DoN) - Nursing Homes Only	Phone	Email	License Number – Nursing Homes Only

7. Facility Contact Person (if different than administrator)

Name	Phone	Email

8. Change in Bed Capacity (if this section is completed, you also must complete Appendix D)

Current Licensed Bed Total	Proposed Beds Increase	Proposed Beds Decrease	Total Licensed Beds after Change

9. Certificate of Need – Required for new health facilities, increase in beds, CHOW, and relocations. (Licensee and facility address in this application must match the approved CON.)

CON Number:	**Approval Date:**

10. Appendices/Other Documents

- ☐ Appendix A for Hospice Applications
- ☐ Appendix B for Psychiatric Applications
- ☐ Appendix B1 for Psychiatric Professional Staff
- ☐ Appendix C for Nursing Homes/LTC Facilities
- ☐ Appendix D for Nursing Homes/LTC Facilities Change in Bed Designations
- ☐ Appendix E for Hospital or Psych Unit Change in Bed Designations

11. Administrator Certification

I certify that the information submitted in this application is true. Additionally:

- All phases of operation, including training programs, comply with state and federal laws prohibiting discrimination [MCL 333.20152(1)(a)].
- Selection and appointment of physicians to the medical staff is without discrimination on the basis of licensure or registration as doctors of medicine or doctors of osteopathic medicine and surgery [MCL 333.20152(1)(b)].

Authorized Person/Administrator	Date

Application submitted by Mail: MI Dept of Licensing & Regulatory Affairs Bureau of Community and Health Systems State Licensing P. O. Box 30664 Lansing, MI 48909	Application submitted by overnight service: MI Dept of Licensing & Regulatory Affairs Bureau of Community and Health System State Licensing 611 West Ottawa Street Lansing, MI 48933

Application packet by E-mail: bchs-statelicensing@michigan.gov Questions: (517) 241-1970

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