Initial License Application to Operate a Rural Emergency Hospital

Regulations affecting the application for licensure of Rural Emergency Hospitals can be found by clicking the Rules tab or link on the applications page.

In addition to the information requested within the application, the following must also be submitted:

1. A completed license application and application fee of $240. Application fees are not refundable.

2. A copy of the Certificate of Need or Letter of Non-reviewability from the State Health Planning and Development Agency.

3. A detailed transition plan (action plan) that lists the specific services that the applicant will retain, modify, add, and/or discontinue upon conversion to a Rural Emergency Hospital (REH), including any distinct part skilled nursing facility services, and a description of the services that it intends to furnish on an outpatient basis as an REH. The transition plan should also address the REH's functional plans for utilizing spaces formerly designated for inpatient beds.

4. A copy of the applicant's transfer agreement with a Medicare-certified hospital that is a level I or level II trauma center.

5. An attestation of compliance with the REH Conditions of Participation, signed by the applicant's administrator or legal representative, submitted on the applicant's letterhead.

6. A complete copy of the application for conversion to an REH submitted to the Centers for Medicare and Medicaid Services (CMS) (CMS-855A) must be provided for the Department's records.

NOTE Due to workload volume, application review takes a minimum of thirty days. Applications must be submitted with all required documents and certificates as noted in the instructions before the review can begin.

Printing of License Certificates
License certificates are now available on-line. When a license is granted or renewed the license certificate can be printed on-line at https://dph1.adph.state.al.us/FacilityCertificatePrint.
A facility ID and pin number will be provided and must be used to print license certificates.

Please note: it is a violation of state law to operate as a Rural Emergency Hospital before you are granted a license from this agency. If you have questions regarding your application, please call (334) 206-5175.

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INITIAL LICENSURE APPLICATION
RURAL EMERGENCY HOSPITAL

Item 1, Applicant. The applicant is the individual, partnership, corporation or other entity which currently holds a license as an acute care hospital (i.e., a rural hospital or critical access hospital) with the Alabama Department of Public Health and will be the governing authority of the facility to whom the license will be granted. The name entered in this section must be exactly as it appears on the current hospital license.

Item 6, Facility Name. The information provided on this line will be entered in the Provider Services Directory and the facility will be referred to by this name exactly as entered on this application. This name is required to include the words “Rural Emergency Hospital”. This name should be the same as on advertisements, facility letterhead, signs in front of the facility and certification information. This name must be unique; that is, it may not be the same as the name of any other licensed facility in Alabama, nor may it be so similar to the name of any other licensed facility that, in the judgment of ADPH staff, there could be any confusion to the public. Governing authorities operating more than one facility may give the facilities they operate similar, but not identical names. The name may be abbreviated if the abbreviation is also used on advertisements, facility letterhead, signs in front of the facility and certification information.

Item 8, Facility Mailing Address. The facility mailing address, street address or post office box must be within the same postal service area as the facility’s physical location.

Item 17, Attestation of Responsible Person. A company officer, board member, administrator or other responsible person must sign the application and make the attestation.

Application Fee. The application fee for a rural emergency hospital is $240. Application fees are not refundable. Make a check or money order payable to the Alabama Department of Public Health.

Attachments. Each attachment must be referenced as a specific applicable item. For example, an attachment to item 13d should be referenced in the document and labeled as such.

STATE OF ALABAMA
DEPARTMENT OF PUBLIC HEALTH
DIVISION OF PROVIDER SERVICES
P.O. BOX 303017 (MAILING ADDRESS)
MONTGOMERY, ALABAMA 36130-3017
THE RSA TOWER, SUITE 700, 201 MONROE STREET, MONTGOMERY, AL 36104
(PHYSICAL LOCATION)

INITIAL LICENSE APPLICATION TO OPERATE A RURAL EMERGENCY HOSPITAL

APPLICATION FEE	FOR DEPARTMENTAL USE ONLY
APPLICATION FEES ARE NOT REFUNDABLE. The fee is $240. MAKE CHECK OR MONEY ORDER PAYABLE TO:	Application Fee ______________
	Check # ______________
ALABAMA DEPARTMENT OF PUBLIC HEALTH	Facility ID # ______________

1. ______________________________
Applicant
(see instructions on page 3)

2. ______________________________
Applicant Address

3. ______________________________
City State Zip Code

4. ______________________________
Applicant Telephone Number

5. ______________________________
Facility Administrator

6. ______________________________
Facility Name
(see instructions on page 3)

7. ______________________________
Facility Physical Address

8. ______________________________
Facility Mailing Address
(see instructions on page 3)

9. ______________________________
City Zip Code County

10. ______________________________
Facility Telephone Number

11. Number of Currently Licensed Inpatient Beds (Licensed Bed Capacity) ____________

12. Current Number of Authorized Beds (Authorized Bed Capacity) ________________

13. Provide the name, phone number, and email address for a knowledgeable person that can supply details about this application.

Name (print) ______________________________

Phone ______________________________

Email ______________________________

14. Applicant Information

a. Applicant is a (check one):

Individual	☐	Nonprofit Corporation	☐	City	☐
Partnership	☐	Hospital Authority	☐	County	☐
Corporation	☐	State	☐	Joint City County	☐
Limited Liability Company	☐	Other: ______________________________ Specify			☐

b. List all the applicant's board members and officers (attach additional paper if necessary).

______________________________ ______________________________

______________________________ ______________________________

c. List the name(s) of any person or business entity that has 5% or more ownership interest in the applicant (attach additional paper if necessary). Also, attach a diagram depicting the organizational structure.

______________________________ ______________________________

______________________________ ______________________________

d. Does this applicant or any of its owners listed in item "c" operate any other health care facility in Alabama or in any other state? YES ☐ NO ☐
If yes, attach a list including the type(s) of facility(s), name(s), address(s), and owner(s).

e. Have any of the facilities listed in item "d" had any adverse licensure action taken against them or been subject to exclusion from the Medicare or Medicaid Reimbursement Programs?
YES ☐ NO ☐
If yes, attach an explanation.

f. Have the applicant, officers or principals ever had a license application denied by this or any other state? YES ☐ NO ☐
If yes, attach an explanation.

15. Has the facility administrator listed in item “5" of this application:

   a. ever been convicted of a crime? YES □ NO □

   b. ever been found guilty of abusing another individual? YES □ NO □

   c. ever had adverse action taken against a professional license, for example nursing home administrator license, attorney license, nurse license, physician license? YES □ NO □

   d. ever been excluded from participation in Medicare or Medicaid Reimbursement Program? YES □ NO □

If a, b, c, or d are yes, attach an explanation for each affirmative answer.

16. Administrator Signature:

I declare, under penalty of perjury, that I have not operated or allowed to be operated, this facility, or any other facility, without a license. I understand and acknowledge that this facility may no longer provide inpatient services (other than distinct part skilled nursing facility services) under its license as a Rural Emergency Hospital but may offer the outpatient services enumerated in the facility's transition/action plan provided with this application. I agree to operate this facility according to the Rules of the Alabama State Board of Health.

______________________________	______________________________
Printed Name	Signature

____
Date

NOTARIZED:

Sworn to and subscribed before me this ________ day of ___________________, 20__.

____
(Notary Public)

17. Attestation of Responsible Person:

I declare, under penalty of perjury, that I have personal knowledge about the statements made in this application and certify that all statements are true and correct. To the best of my knowledge, neither the applicant nor any of the principals, including myself, the owners, and the administrator, have operated or allowed to be operated, this facility, or any other facility, without a license.
I further understand and acknowledge that this facility may no longer provide inpatient services (other than distinct part skilled nursing facility services) under its license as a Rural Emergency Hospital but may offer the outpatient services enumerated in the facility's transition/action plan provided with this application.
I certify that I am authorized to make these representations on behalf of the applicant.

Signature:______________________________ Print Name:______________________________

Title/Position:______________________________ Date:______________________________

NOTARIZED:

Sworn to and subscribed before me this _________ day of_________________, 20__.

____
(Notary Public)

MANDATORY ACKNOWLEDGMENT NOTICE

Pursuant to *Alabama Code* section 30-3-194, every applicant seeking from a state agency a license, certificate, permit, or authorization to engage in a profession, occupation, or commercial activity, must provide the social security number of the person signing the application, whether as an individual or on behalf of an entity or corporation. Failure to provide this social security number will result in the denial of the application.

Print or Type Name of Person Signing Application: ______________________________

Social Security Number of Person Signing Application: ___________________________

Print or Type the Facility Name: ____

THIS PAGE **IS NOT** PUBLIC RECORD