Pre-License Filing

THIS FORM WAS REVISED IN AUGUST 2019 – PLEASE READ CAREFULLY -

THIS FILING IS REQUIRED FOR ALL HEALTHCARE FACILITIES THAT MUST SUBMIT TO ARCHITECTURAL REVIEW AND MUST BE SUBMITTED AND APPROVED BEFORE PLANS ARE SUBMITTED

– PLEASE READ CAREFULLY -

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

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

1. A completed Pre-License filing.

2. A copy of the local zoning approval.

3. Organizational documents such as: Articles of Incorporation, Articles of Organization, LLC Agreement, Partnership Agreement, or Statement of Sole Proprietorship, under which the facility will operate.

4. A copy of the Certificate of Existence (for domestic entities) or the certificate of registration (for foreign entities issued by the Alabama Secretary of State), as proof of its authority to transact business in the state of Alabama.

5. A facility diagram illustrating planned licensed beds and room numbers. Floor plans on letter sized paper if preferable.

6. All facilities **except** abortion centers, regular assisted living facilities, independent clinical laboratories and independent physiological laboratories are required to obtain State Health Planning and Development Agency (SHPDA) approval.

   No fee for Pre-License Filing.

Technical Services will not review architectural plans before this filing is reviewed by the Provider Services Unit (Technical Service Unit (334) 206-5177).

ADDITIONAL INFORMATION
PRE-LICENSURE FILING

Item 1, Entity. The entity is the individual, partnership, corporation or other entity which will be the governing authority of the facility and to whom the license may be granted **(not the facility name or the individual completing the filing, unless the entity is an individual)**. The name entered in this section must be exactly as printed on the legal document establishing the entity. A copy of the legal document must accompany this filing. Entities established in a state other than Alabama must register to conduct business in Alabama with the Secretary of State's Office. A copy of the registration must also accompany this filing. If the facility is leased, the lessee should be indicated as the entity. The lessee may be an individual, partnership, corporation, or other entity. **NOTE - The entity must be the operator of the facility, the entity that hires or fires the administrator, determines patient care issues, makes payment for facility obligations, etc.** Contact the department if there are questions regarding who may be the licensee.

Freestanding emergency departments must list the parent hospital.

Item 6, Bed/Station Capacity. Total number of beds or stations that the facility will operate. This item does not apply to freestanding emergency departments.

Item 7, 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 filing. 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 9, 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.

Please note: it is a violation of state law to provide healthcare facility services before you are granted an appropriate license from this agency. If you have any questions about your filing, please call (334) 206-5175.

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 710, 201 MONROE STREET, MONTGOMERY, AL 36104
(PHYSICAL LOCATION)

PRE-LICENSE FILING

1._____
Entity
(see instructions on page 2)

2._____
Entity Address

3._____
City State Zip Code

4._____
Entity Telephone Number

5._____
Facility Administrator (If known)

6._____
Facility Bed/Station Capacity
(see instructions on page 2)

7._____
Name of the Facility
(see instructions on page 2)

8._____
Facility Physical Address

9._____
Facility Mailing Address
(see instructions on page 2)

10. _____
City Zip Code County

11. Have architectural plans been submitted to the Technical Services Unit? YES ☐ NO ☐

12. Select facility type:

Abortion/Reproductive Health Ctr. ☐ Ambulatory Surgical Treatment Ctr. ☐ Pediatric ☐ Eye ☐ Assisted Living Facility: Family (2-3 beds) ☐ Group (4-16 beds) ☐ Congregate (17 + beds) ☐ Spec. Care Assisted Living Facility Group (4-16 beds) ☐ Congregate (17 + beds) ☐	Birthing Center ☐ Cerebral Palsy Treatment Ctr. ☐ End Stage Renal Disease ☐ Hospice: In-Home ☐ In-Patient ☐ Hospital: General ☐ Specialized ☐ Freestanding Emergency Dept ☐ Specify specialization: _____ _____	Independent Clinical Laboratory ☐ Independent Physiological Laboratory ☐ Nursing Home: Skilled Nursing Facility ☐ Nursing Facility ☐ ICF/MR ☐ Rehabilitation Center ☐ Sleep Disorders Center ☐

13. Entity Information
    a. Entity 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 entity'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 entity (attach additional paper if necessary). Also, attach a diagram depicting the organizational structure.

_____ _____

_____ _____

_____ _____

    d. Does this entity 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 you checked 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 entity, officers or principals ever been convicted of a crime? YES ☐ NO ☐ If yes, attach an explanation.

g. Have the entity, officers or principals ever been found guilty of abusing another individual? YES ☐ NO ☐ If yes, attach an explanation.

h. Have the entity, officers or principals ever had adverse action taken against a professional license, for example, nursing home administrator license, attorney license, nurse license, physician license? YES ☐ NO ☐ If you checked yes, attach an explanation.

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

14. Has the facility **administrator** listed in item “5" of this filing:

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.

15. Provide the name, phone number, and email address of a knowledgeable person who can supply details about this filing. **PLEASE TYPE OR PRINT CLEARLY.**

Name _____

Address _____

City-State-Zip _____

Phone _____ Email _____