*NOTICE *
THIS APPLICATION WAS REVISED IN JULY 2016
– PLEASE READ CAREFULLY -

Initial License Application
To Operate a Cerebral Palsy Treatment Facility

Regulations affecting the application for licensure of Cerebral Palsy Treatment Centers 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 $240 application fee plus $6 per bed excluding the first ten beds. Application fees are not refundable.

2. 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. Corporations, Limited Partnerships and Limited Liability Companies must provide approved documentation from the Office of the Secretary of State to conduct business in the State of Alabama.

3. Approval from the State Health Planning and Development Agency (SHPDA). This approval may take the form of a Certificate of Need or other approval as the SHPDA determines appropriate.

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

5. A copy of the Certificate of Completion. Upon successful review of the application, and building approval from Technical Services, a copy of the application will be forwarded to the Division of Health Care Facilities. A staff member from the unit will contact you regarding an on-site licensure visit to determine if the facility meets minimum requirements for a state license.

A license may be granted upon approval of the application, building approval from Technical Services, and a successful on-site survey.

NOTE Due to workload volume, application review takes a minimum of thirty days. An on-site survey (if required) could add considerable time to completion of the licensure process. Applications must be submitted well in advance of anticipated start of operations. Applications must be submitted with all required documents and certificates as noted in the instructions before the review can begin.

You are welcome to contact the department for ways to expedite the application process to shorten the review time. The earliest date a license can be granted is the first day the complete application and any surveys have been approved by the Department. [For certified health care facilities and agencies, application to the appropriate MAC is recommended 180 days in advance of the anticipated start of operations.]

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 cerebral palsy treatment facility before you are granted a license from this agency. If you have questions regarding your application, please call (334) 206-5175.

<REMAINDER OF PAGE INTENTIONALLY LEFT BLANK>

ADDITIONAL INSTRUCTIONS
CEREBRAL PALSY TREATMENT FACILITY

Item 1, Applicant. The applicant is the individual, partnership, corporation or other entity who will be the governing authority of the facility and to whom the license will be granted **(not the facility name or the individual completing the application, unless the applicant 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 application. 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 application. If the facility is leased, the lessee should be indicated as the applicant. The lessee may be an individual, partnership, corporation, or other entity. . **NOTE - The applicant 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.**

Item 6, Number of Beds. Total number of beds the facility will operate. This number cannot exceed the number of beds issued on the Certificate of Need.

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 application. 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.

Item 16, 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 cerebral palsy treatment center is $240 plus $6 per bed excluding the first ten beds. 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 a specific applicable item. For example, attachment to item 13 d 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 CEREBRAL PALSY TREATMENT FACILITY

1. _____
Applicant
(see instructions on page 3)

2. _____
Applicant Address

3. _____
City State Zip Code

4. _____
Applicant Telephone Number

5. _____
Facility Administrator

6. _____
Number of Beds
(see instructions on page 3)

7. _____
Facility Name
(see instructions on page 3)

8. _____
Facility Physical Address

9. _____
Facility Mailing Address
(see instructions on page 3)

10. _____
City Zip Code County

11. _____
Facility Telephone Number

APPLICATION FEE APPLICATION FEES ARE NOT REFUNDABLE. **The fee is $240 plus $6 per bed excluding the first ten beds** MAKE CHECK OR MONEY ORDER PAYABLE TO: ALABAMA DEPARTMENT OF PUBLIC HEALTH	FOR DEPARTMENTAL USE ONLY Application Fee _____ Check # _____ Facility ID # _____

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

13. 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.

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

Name _____ Title _____

Address _____

City-State-Zip _____

Phone _____ Email _____

15. 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 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)

16. 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 certify that I am authorized to make this representation 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